

**SPECIAL REPORT**

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# **National Estimates of Mental Health Insurance Benefits**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)



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**U.S. Department of Health and Human Services**  
Substance Abuse and Mental Health  
Services Administration  
Center for Mental Health Services

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# Executive Summary

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**T**his study provides estimates of the number of individuals in the United States in 1999 who had mental health benefits as a part of their health insurance coverage, the subset of those individuals who had mental health benefits that met or exceeded a benchmark level of generosity, the number of individuals with parity in their mental health benefits, and the number of individuals potentially subject to state and Federal mental health parity laws.

Mental health benefits are assessed in terms of the types of services covered (inpatient care, outpatient care, and prescription drugs), dollar limits (annual expenditures and lifetime expenditures), utilization limits (number of days of inpatient care and number of outpatient visits), and cost sharing (deductibles, co-insurance, and co-payments). The benchmark level of generosity is defined in this report in terms of the types of services covered (inpatient and outpatient care and prescription drug coverage) and utilization limits (20 inpatient days and 30 outpatient visits). Full mental health parity is defined as mental health benefits with the same covered services, dollar limits, utilization limits, and cost sharing as the plan's medical/surgical benefits.

## **Mental Health Insurance Coverage**

- In 1999, more than three-quarters (76 percent) of the U.S. population had mental health benefits as a component of their health insurance. Approximately 18 percent of the population had no mental health insurance benefits; the remaining six percent had unknown mental health

benefits. Of the 18 percent with no mental health benefits, the vast majority (84 percent) had no health insurance whatsoever, while a small portion (16 percent) had health insurance with no mental health benefits.

- The proportion of the population with mental health insurance benefits varied moderately from state to state. The proportion of individuals in 1999 with mental health insurance ranged from a high of about 80 percent to a low of about 69 percent.

## **Generosity of Coverage of Mental Health Benefits**

- In 1999, approximately 59 percent of individuals with private, employer-sponsored health insurance through a firm with 10 or more employees had mental health benefits meeting the benchmark level. The percentage of individuals with mental health benefits meeting the benchmark increased with firm size. These results are based on the assumption that health plans with parity in mental health benefits met or exceeded the benchmark.

- Of those with health insurance, 52 percent had mental health coverage that met or exceeded the benchmark of 30 inpatient days, 20 outpatient visits, and prescription drug coverage. Approximately 23 percent had mental health benefits less generous than the benchmark, and three percent had no mental health benefits.

## Parity in Mental Health Benefits

- Among those with employer-sponsored health insurance, individuals in smaller firms were more likely to have parity in mental health benefits than their larger-firm counterparts. Approximately 23 to 24 percent of individuals who had health insurance provided through firms with 10 to 499 employees had mental health benefits equal to those of their medical benefits. In contrast, only 6 to 8 percent of individuals who had health insurance provided through firms with 500 or more employees had mental health benefits at parity.
- In 1999, 37 percent of individuals with health insurance coverage had parity in mental health benefits. The Medicaid program and private, employer-sponsored insurance are the two largest sources of health insurance coverage that provide mental health benefits at parity.
- In 1999, 13 states mandated full mental health parity in the private employer-sponsored health insurance market, requiring full equality of utilization and dollar limits, as well as cost sharing. An estimated 9.8 million (8 percent) of the 124.6 million individuals who had health insurance through private employer-sponsored plans

were in health plans subject to state mental health parity requirements.

- If all states had a full financial mental health parity law in effect in 1999, with a small employer exemption for firms with 50 or fewer employees, the laws ultimately would have reached only 36 percent of individuals with private, employer-sponsored health insurance. Had all states implemented full financial mental health parity laws without small business exclusions, only an additional 19 percent would have been covered, bringing the total covered by the law to 55 percent of the private, employer-sponsored insurance market. These individuals represent approximately 25 percent of the total U.S. population.
- In 1999, the Mental Health Parity Act of 1996 (MHPA) ensured parity in some aspects of mental health benefits for approximately 42 percent of the U.S. population. Another 12 percent were exempt, either due to the small employer exemption (10 percent), or because the individual's plan did not cover mental health (2 percent). Enrollees in Federal programs not covered by the law accounted for another 24 percent of the total population. Individuals with individually purchased insurance, also not subject to the law's provisions, made up another 4 percent of the population. Data are insufficient to estimate whether individuals with health insurance from outside the household (2 percent) or non-working individuals with employer-sponsored health insurance were subject to the law (1 percent). The remaining individuals (15 percent) were uninsured.



# Introduction

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More than one in five Americans has a diagnosable mental disorder some time in his or her lifetime, yet only about half of those individuals receive professional mental health treatment (U.S. Department of Health and Human Services, 1999). One major determinant of an individual's access to mental health care is whether he or she has health insurance that includes mental health benefits. Research over the past decade (reviewed in Appendix A) has found that although most individuals in the United States had health insurance, and most with health insurance had mental health benefits, most mental health benefits were substantially less generous than the medical/surgical benefits provided by the same plans. Public concern over unequal treatment led to passage of the Mental Health Parity Act of 1996 (MHPA) (42 USC § 300gg-5), which required employers with 50 or more employees that were providing mental health benefits to apply the same dollar limits to mental health benefits as they did to their medical/surgical benefits. Although the MHPA technically “sunsetted” in September 2001, subsequent laws have extended the original statute's provisions through the end of 2003.

Considerable attention has been paid to the issue of parity as a way to improve mental health insurance coverage, but relatively little is known about the extent of current levels of coverage and about generosity of benefits. Even if current efforts to create parity mandates prove successful, little is known about the potential impact of these mandates on the number of people who would be affected. To broaden the current understanding of these issues, the study documented in this report addresses the following questions:

How many people in the United States have mental health benefits as a part of their health insurance?

How generous are the mental health benefits for those who have them? What limits are placed on mental health benefits, and how prevalent are those limits? How do the limits vary by source of insurance?

What proportion of the population falls under the jurisdiction of Federal and state parity laws?

Chapter II of this report presents estimates of the number of individuals covered by each source of mental health insurance coverage; Chapter III examines mental health benefit generosity by reporting the number of individuals with mental health benefits at a benchmark standard; and Chapter IV presents the number of individuals subject to

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Federal and state parity laws. Chapter V highlights the principal findings of the study.

The main text is supplemented with several appendices. Appendix A presents details regarding each source of mental health insurance. Appendix B presents the methods used to produce the estimates presented in Chapters II, III, and IV. Appendix C lists the members of the expert panel who provided guidance throughout this study. Appendix D presents the limits for mental health benefits in the 33 separate State Children's Health Insurance Programs (S-SCHIP). Detailed state-by-state data tables on 1) health insurance by primary source and on 2) private employer-sponsored health insurance by firm size and self-insured status are available from the authors at Mathematica Policy Research, Inc., upon request.

## **A. Data and Methods**

The data sources for the analysis include the March 2000 Current Population Survey (CPS), the 1999 Medical Expenditure Survey—Insurance Component (MEPS-IC), and the Mercer Worldwide National Survey of Employer-Sponsored Health Plans. Each survey uses a nationally representative probability sample, with 1999 as the reference period. The CPS is sponsored by the U.S. Bureau of the Census and contains data from a sample of approximately 47,000 households concerning their health insurance coverage. The MEPS-IC is sponsored by the U.S. Department of Health and Human Services (DHHS) Agency for Healthcare Research and Quality (AHRQ), and contains data from a sample of approximately 20,000 public and private employers concerning the health insurance benefits they provide to their employees. The National Survey of Employer-Sponsored Health Plans, sponsored

by Mercer Worldwide, contains data from a sample of approximately 2,700 private employers regarding detailed provisions of their health insurance plans.

The unit of analysis in this study is the individual (policyholders and covered family members). Since the CPS is the only one of the three databases that contains individualized information, it was used as the primary database. The other two databases were used to impute values not otherwise provided by the CPS. Imputed information includes greater detail on firm size and the provisions of the health plan than is available in the CPS.

As in most studies, the results presented are based on several key assumptions. First, in cases where persons reported more than one source of health insurance in the CPS, individuals are categorized in one health insurance group according to a hierarchy of insurance sources (Appendix B provides a more detailed discussion of the hierarchy). Second, because the CPS does not record Medicaid and State Children's Health Insurance Programs (SCHIP) enrollment separately, enrollment in SCHIP was estimated from administrative data, and Medicaid enrollment was estimated as the residual. Gaps in data were estimated by imputing the following:

For 14 states in which the MEPS-IC sample was not large enough to support state-level estimates, we assumed the proportion of self-insured firms with more than 50 employees was equal to the national proportion.

For 11 states, the MEPS-IC sample did not support reliable estimates of the percentage of firms with 10–49 employees. Thus, national estimates of the percentages were applied to these 11 states.

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Hawaii, Maine, and Virginia have small employer exemptions in their parity laws for firms with 25 or fewer employees. Due to the size groupings for businesses in the available data, estimates of the number of individuals exempted from parity laws under the small business exclusions in these states are not possible. To accommodate the dearth of data, estimates for the number of individuals exempted from parity laws in these states

were based on the assumption that the exemption protected employers with fewer than 50 employees. Therefore, the effect of parity laws in these three states is slightly underestimated.

A complete description of the data sources and a technical discussion of the imputation methods used in the study can be found in Appendix B.







# Mental Health Insurance Coverage

This chapter presents estimates of the number of individuals who had mental health insurance benefits in 1999. Section A briefly describes sources of health and mental health insurance coverage. Section B estimates the number of individuals with health insurance by primary source of coverage. Section C estimates the percentage of individuals with mental health insurance among those with health insurance by source of coverage. Finally, Section D estimates the proportion of the total U.S. population with mental health benefits and includes state estimates of mental health coverage.

## A. Sources of Health and Mental Health Insurance

The following is a brief description of the major sources of mental health insurance in the United States. These are listed in order, based on the number of individuals covered by each source. A more extensive discussion of these insurance sources can be found in Appendix A.

### 1. Employer-Sponsored Plans

Nearly half of the U.S. population is covered by employer-sponsored health insurance. A large majority of employers provide mental health insurance, but they impose more restrictive limits on that coverage than on the medical and surgical coverage they offer. Since the Mental Health Parity Act (MHPA) of 1996 prohibited employers from imposing different dollar limits on mental health coverage, employers increasingly have substituted utilization limits for dollar limits. In 1999, 80 percent of individuals with employer-sponsored mental health insurance had inpa-

tient day and/or outpatient visit limits on their coverage (Sturm and Pacula, 2000).

Rather than contracting with health insurers, many employers—particularly large firms—have implemented self-funded plans that pay physicians and hospitals directly. The provisions of the Employee Retirement Income Security Act (ERISA) of 1974 exempt most self-funded plans from state mandates that require parity in coverage for mental health services and other health care. In a 1997 survey of employer-sponsored behavioral health benefits (Buck et al., 1999), employers indicated that only about 15 percent of their “most prevalent” plans (i.e., those with the largest enrollment) were self-funded. The survey found that the larger the number of employees, the greater the likelihood that the firm had a self-funded plan.

### 2. Medicare

Medicare is the largest publicly sponsored health insurance program in the United States, covering an estimated 36.1 million individuals in 1999. The majority of

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Medicare beneficiaries—87 percent in 1999 (Centers for Medicare and Medicaid Services, 2000a)—are aged 65 years and older.

Approximately 13 percent of the Medicare population are under age 65 and qualify because either they are totally or permanently disabled, or they have been diagnosed with end-stage renal disease (ESRD). Medicare's benefit package is divided into Parts A and B. Part A provides hospital insurance; Part B provides medical insurance that covers physician services and outpatient expenses.

Because of the limitations in Medicare's benefit package, 88 percent of Medicare beneficiaries in 1999 had some form of supplemental insurance coverage (Laschober et al., 2002). Major sources of this supplemental coverage included:

- **Medicare+Choice (M+C).** Medicare+Choice, Medicare's managed care program, allows health plans to offer supplemental benefits not covered in the traditional Medicare benefit package. In 1999, approximately 16 percent of Medicare beneficiaries were enrolled in Medicare+Choice (Health Care Financing Administration, 1999a); 84 percent of these Medicare+Choice enrollees had prescription drug coverage (Cassidy and Gold, 2000).
- **Medigap insurance.** In 1999, 24 percent of Medicare beneficiaries had supplemental coverage under a Medigap plan (Laschober et al., 2002). Two-thirds of Medigap plans are standard policies that cover the co-insurance for both Part A and Part B, the Part A deductible, and 365 additional hospital days during a beneficiary's lifetime. (These additional hospital days are for

general hospitals only and do not extend the 190-day limit for inpatient care at psychiatric hospitals). Only about 27 percent of Medicare beneficiaries with Medigap supplemental insurance had some drug coverage in 1999 (Laschober et al., 2002).

- **Employer-sponsored retiree coverage.** Approximately 33 percent of Medicare beneficiaries in 1999 had supplemental health insurance through a current or former employer; 83 percent of these beneficiaries had some drug coverage (Laschober et al., 2002).
- **Dual eligibility with Medicaid.** Low-income Medicare beneficiaries can qualify for supplemental Medicare coverage through state Medicaid programs; in 1999, approximately 11 percent of Medicare beneficiaries had supplemental coverage from Medicaid.

### **3. Medicaid**

Medicaid is a means-tested entitlement program for low-income individuals, financed jointly by the Federal government and the states. Generally, each state sets its own eligibility requirements beyond federally mandated minimum levels, based on a combination of income, assets, and categorical aid status. The most common categories of enrollees are low-income children, pregnant women, the elderly, the disabled, and parents meeting specific income thresholds. The Federal government mandates that all states must cover a core benefit package that includes inpatient and outpatient hospital services, as well as early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. States also may choose to cover optional services, such as prescription drugs and clinic services.

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#### **4. State Children's Health Insurance Program (SCHIP)**

Congress enacted the State Children's Health Insurance Program (SCHIP) in 1997 to expand health insurance coverage among children. SCHIP provided the states with Federal matching funds to insure low-income children who were not eligible for Medicaid by expanding their Medicaid program (M-SCHIP), by designing a separate child health program (S-SCHIP), or by combining the two approaches.

M-SCHIP must provide the full Medicaid benefit package that the individual state provides.

S-SCHIP must be comparable to one of the following benchmark plans: the Federal Employees Health Benefits standard option plan; the specific state's employee health benefit plan; the health maintenance organization (HMO) with the largest commercially enrolled population in the individual state; or another package approved by the Federal government.

#### **5. Federal Employees Health Benefits Program (FEHBP)**

The Office of Personnel Management (OPM) oversees the FEHBP, the health insurance program for employees of the Federal government. Beginning in 2001, the FEHBP required full mental health parity for all health plans participating in the program. Utilization limits and cost sharing for health plan coverage of mental illness must be at parity with limits and cost sharing for medical, surgical, and hospital services.

#### **6. TRICARE**

TRICARE is the health system operated by the U.S. Department of Defense for active-duty members of the armed forces and their

dependents, military retirees and their dependents, and surviving spouses of deceased active-duty or retired military service members. The TRICARE program has three options: an HMO (TRICARE Prime), a preferred provider organization (PPO) (TRICARE Extra), and a fee-for-service option (TRICARE Standard, formerly CHAMPUS).

#### **7. Veterans Affairs**

The U.S. Department of Veterans Affairs (VA) provides care to eligible veterans, generally at VA hospitals, as well as enrollment and eligibility for care based on seven priority groups, in accordance with the veteran's health status and financial circumstances. The VA provides unlimited inpatient and outpatient mental health services and prescription drugs; cost sharing depends on an individual's priority level.

#### **8. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)**

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is the federally administered, fee-for-service health benefits program for dependents and survivors of veterans who have a total, permanent disability, or who died from a disability incurred or aggravated during active-duty military service. Unlike those receiving care through the VA, CHAMPVA enrollees may receive care through any provider.

#### **9. Indian Health Service (IHS)**

The Indian Health Service, part of the U.S. Department of Health and Human Services (DHHS), provides health care to American Indians and Alaska Natives who are members

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of federally recognized tribes. IHS facilities are located on or near Indian reservations. American Indians and Alaska Natives may receive care if they live in the geographic area where the facility is located. The IHS Mental Health and Social Services program, a community-oriented clinical and preventive services program, offers mental health services, primarily on an outpatient basis. Inpatient psychiatric services are provided under contract at local general, private psychiatric, and state psychiatric hospitals; virtually no partial hospitalization, transitional living, or child residential services are offered.

#### *10. Individually Purchased Insurance*

Individuals without access to health insurance in the group market may elect to purchase insurance in the individual market. Such individuals include early retirees without retiree benefits, persons who are self-employed, those whose employers do not offer health insurance, and individuals who have exhausted their continued group coverage allowable through the Consolidated Omnibus Reconciliation Act (COBRA) of 1986.

Unlike the group health insurance market, most states allow companies selling individual health insurance policies to accept or deny an applicant based on the individual's health status, including their mental health. Applicants often are required to provide a medical history and may have to undergo a medical examination (Gabel, 2002). Only 11 states require every insurer in the individual market to accept all applicants, regardless of health status (U.S. General Accounting Office, 2002, February).

### **B. Covered Lives With Health Insurance**

Estimating the number of individuals with mental health insurance benefits is a three-step process. First, the number of individuals covered by each source of health (as opposed to mental health) insurance is estimated. Next, the proportion of individuals with each type of health insurance who have mental health benefits is estimated. Finally, the figures from the first and second steps are multiplied together to yield an estimate of the number of individuals with mental health insurance benefits.

Table II.1 presents the number and percentage of the U.S. population, by age group, reporting health insurance by their primary source of insurance in 1999. The figures are taken primarily from the Current Population Survey (CPS). However, the CPS combines SCHIP with Medicaid. (Detailed state-by-state data tables on 1) health insurance by primary source and on 2) private employer-sponsored health insurance by firm size and self-insured status are available from the authors at Mathematica Policy Research, Inc., upon request). The estimates of individuals covered by SCHIP programs were derived from Centers for Medicare and Medicaid Services administrative data (Centers for Medicare and Medicaid Services, 2000b).

Slightly more than 15 percent, or 42 million individuals, had no health insurance coverage in 1999. By far, the most common source of health insurance was private employer-sponsored insurance, covering more than 45 percent of the U.S. population, or 125 million individuals. Medicare, the

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Federal program designed primarily to provide health insurance to those aged 65 years and older, was the largest public source of health care insurance, covering 13 percent of the population, or 36 million individuals. The Medicare figures include Part A, covering hospital costs, and Part B, covering physician costs. Nearly all individuals aged 65 years and older reported Medicare as their primary source of health insurance.

The two Federal-state programs providing health insurance to low-income families—Medicaid and SCHIP—together covered more than 8 percent of the population, or 23 million individuals. Children constituted the majority of individuals for whom Medicaid was the primary source of health insurance. State and local government employee health plans covered nearly as many individuals as Medicaid and SCHIP combined—22 million. Less common sources of health insurance include:

- Insurance purchased by individuals, as opposed to health insurance purchased by a group of individuals, (e.g., an employer-sponsored group)

- FEHBP, the health insurance provided by the Federal government to its civilian employees and their dependents
- TRICARE, the health insurance program of the U.S. Department of Defense, provided to members of the armed forces and their dependents
- Two programs operated by the VA—direct care for veterans in VA hospitals and a fee-for-service plan for dependents of veterans, labeled CHAMPVA
- Health care provided by IHS, which delivers health care through health facilities located on or near Indian reservations to American Indians and Alaska Natives who are members of federally recognized tribes

Figure II.1 presents the primary source of health insurance coverage for individuals, by age, in 1999. In these figures, the category “other public” includes individuals enrolled in the FEHBP, state/local government employee plans, TRICARE, CHAMPVA, VA, and IHS. The Medicaid group also includes SCHIP enrollees.

Table II.1. U.S. Population by Primary Source of Health Insurance, 1999

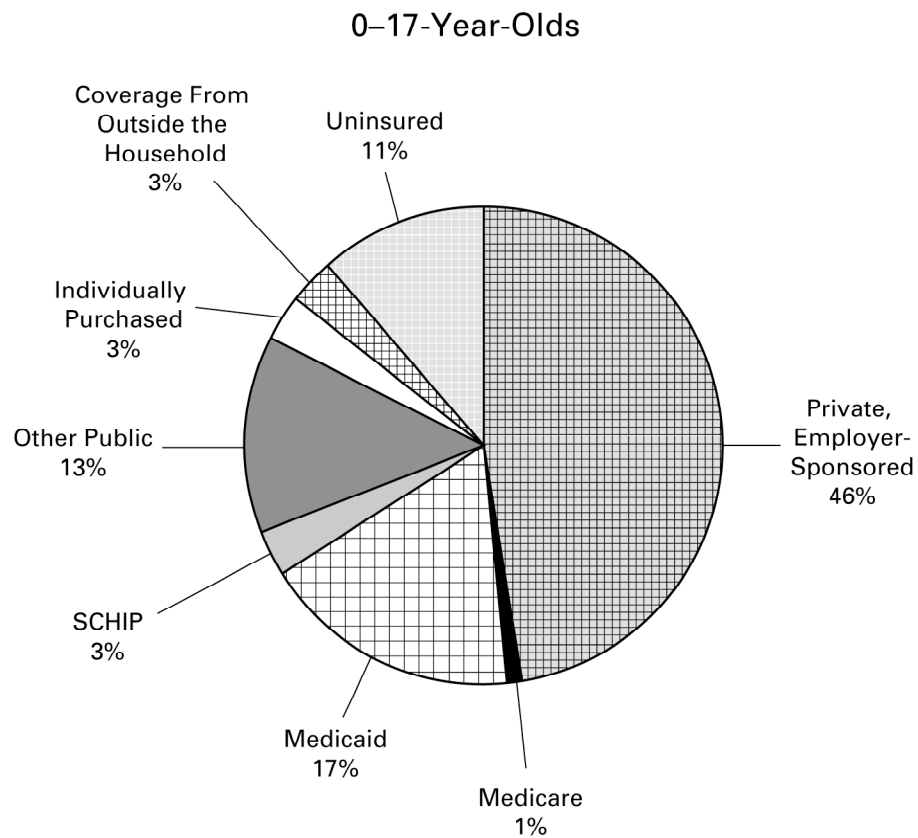
| Primary Source of Health Coverage   | Covered Individuals (millions) | Population Covered (percent) | Population Covered by Age Group (percent, except where noted) |          |              |
|---|--------------------------------|------------------------------|---|----------|--------------|
|   |                                |                              | 0 to 17   | 18 to 64 | 65 and older |
| Medicare  | 36.1                           | 13.2                         | 0.5   | 2.6      | 95.7         |
| Medicaid  | 21.2                           | 7.7                          | 16.9  | 5.3      | 0.1          |
| State Children's Health Insurance Program (SCHIP)                                   | 2                              | 0.8                          | 2.8   | 0        | 0            |
| M-SCHIP   | 0.7                            | 0.3                          | 1   | 0        | 0            |
| S-SCHIP   | 1.3                            | 0.5                          | 1.8   | 0        | 0            |
| Federal Employee Health Benefit Plan (FEHBP)  | 5.2                            | 1.9                          | 2   | 2.3      | 0.1          |
| State/Local Government Employer Plans   | 22.5                           | 8.2                          | 8.4   | 9.6      | 0.4          |
| Private, Employer-Sponsored   | 124.6                          | 45.5                         | 46.9  | 53.2     | 2            |
| TRICARE   | 4.9                            | 1.8                          | 2.1   | 2        | 0.1          |
| Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) | 0.3                            | 0.1                          | 0.1   | 0.1      | 0            |
| Veterans Affairs (VA)   | 0.5                            | 0.2                          | 0   | 0.2      | 0.1          |
| Indian Health System (IHS)  | 0.3                            | 0.1                          | 0.2   | 0.1      | 0            |
| Individually Purchased  | 9.6                            | 3.5                          | 3.3   | 4.2      | 0.2          |
| Coverage From Outside the Household <sup>a</sup>                                    | 4.6                            | 1.7                          | 3   | 1.5      | 0            |
| Uninsured   | 42.3                           | 15.4                         | 13.7  | 18.9     | 1.3          |
| Total Number of Individuals (millions)  | 274.1                          | --                           | 72.3  | 169.1    | 32.6         |

Source: March 2000 Current Population Survey supplemented with administrative data on SCHIP enrollment in 1999 (Centers for Medicare and Medicaid Services, 2000b).

Note: For individuals with more than one source of insurance, the primary source of coverage was determined by the study hierarchy. Estimates of individuals in certain categories; e.g., VA, thus may be lower than administrative records for those sources would indicate.

<sup>a</sup>The individual is covered under a health insurance policy whose policyholder does not reside in the household. For such individuals, the source of insurance is not known.

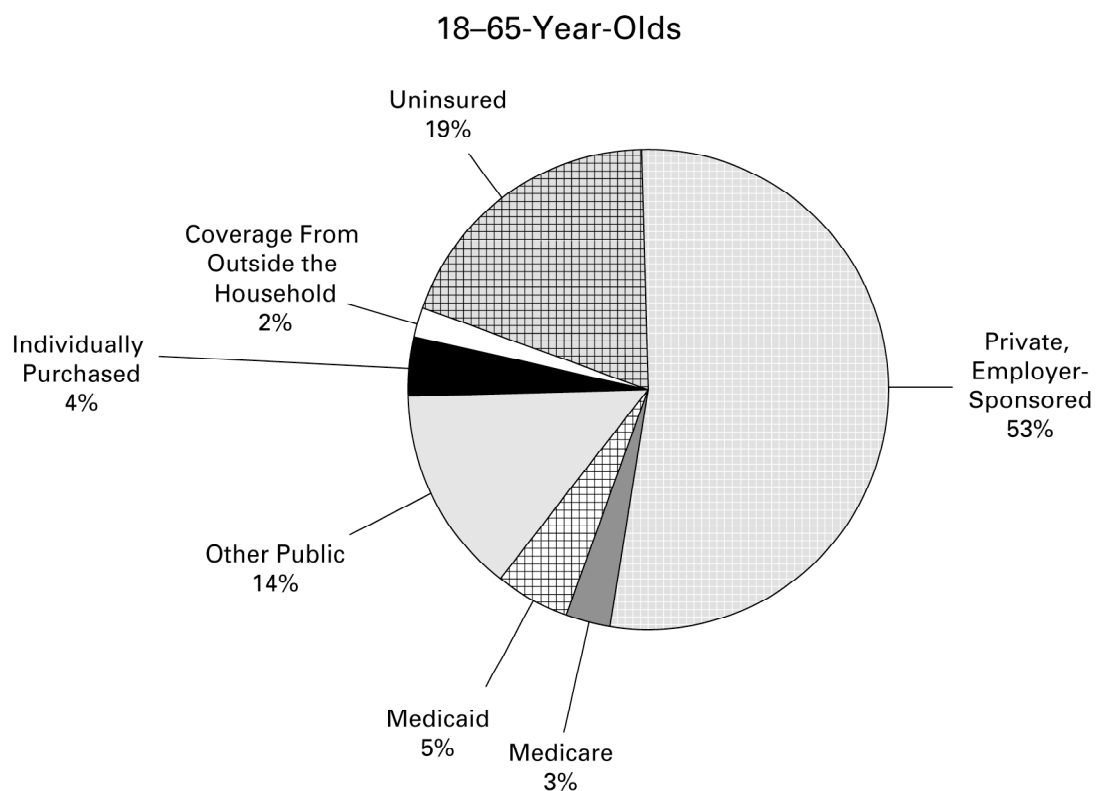
Figure II.1. Primary Source of Health Insurance Coverage in U.S., by Age, 1999



Source: 2000 Current Population Survey.

Note: "Other Public" includes Federal Employee Health Benefit Plan, state/local government employee plans, TRICARE, CHAMPVA, VA, and IHS. "Medicaid" includes SCHIP enrollees.

Figure II.1. Primary Source of Health Insurance Coverage in U.S., by Age, 1999 (Continued)

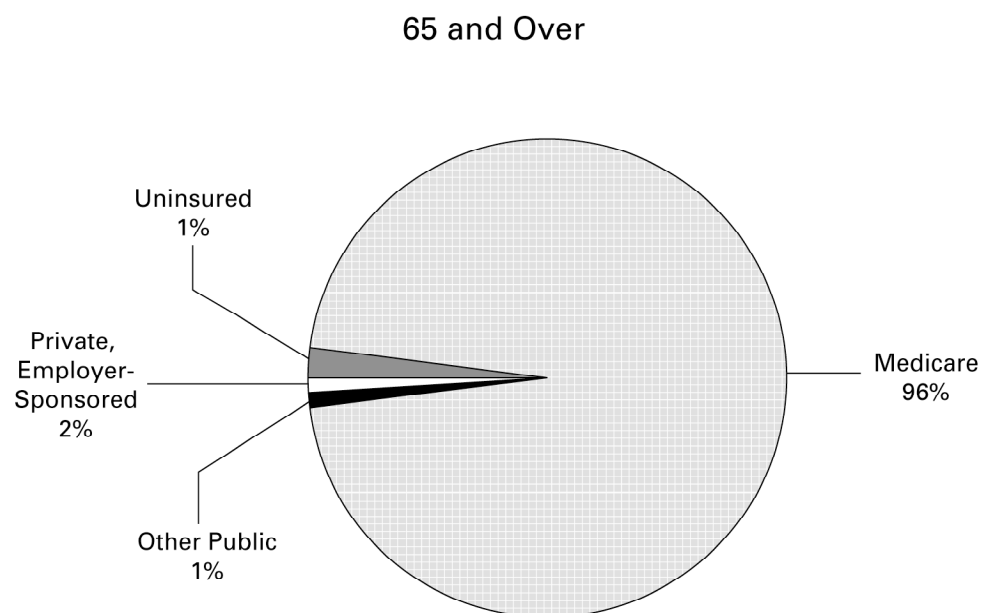


Source: 2000 Current Population Survey.

Note: "Other Public" includes Federal Employee Health Benefit Plan, state/local government employee plans, TRICARE, CHAMPVA, VA, and IHS. "Medicaid" includes SCHIP enrollees.



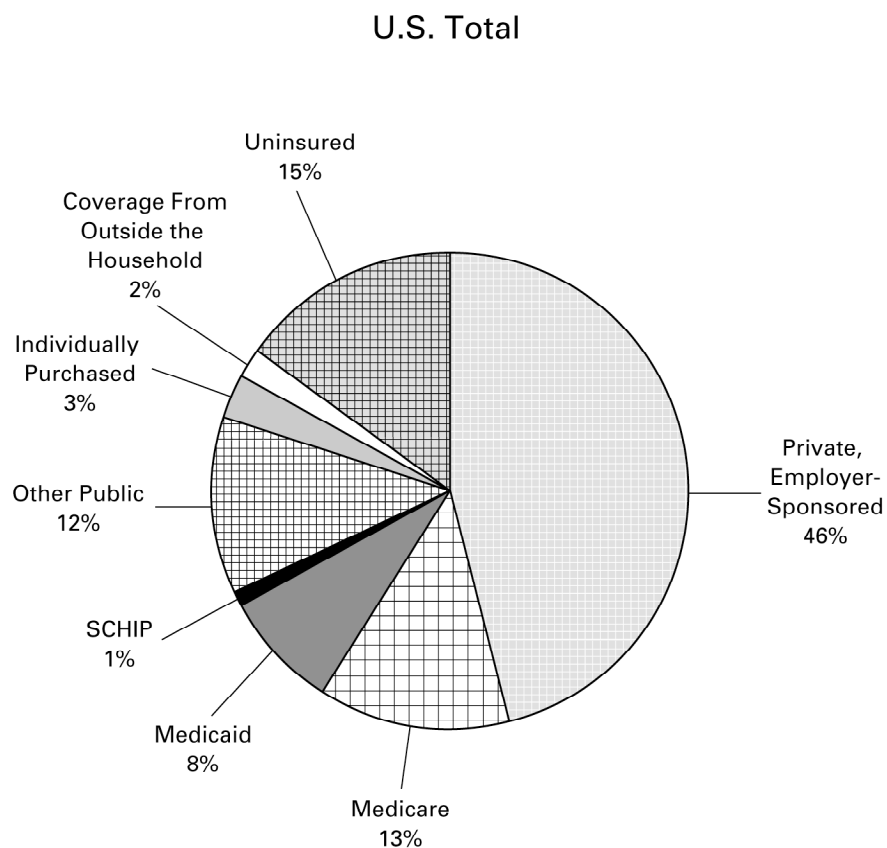
Figure II.1. Primary Source of Health Insurance Coverage in U.S., by Age, 1999 (Continued)



Source: 2000 Current Population Survey.

Note: "Other Public" includes Federal Employee Health Benefit Plan, state/local government employee plans, TRICARE, CHAMPVA, VA, and IHS. "Medicaid" includes SCHIP enrollees.

Figure II.1. Primary Source of Health Insurance Coverage in U.S., by Age, 1999 (Continued)



Source: 2000 Current Population Survey.

Note: "Other Public" includes Federal Employee Health Benefit Plan, state/local government employee plans, TRICARE, CHAMPVA, VA, and IHS. "Medicaid" includes SCHIP enrollees.

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### **C. Mental Health Insurance Among Those With Health Insurance**

Table II.2 presents the percentage of people with health insurance who also had both inpatient and outpatient mental health benefits, by source of health insurance. For example, the table indicates that 96 percent of individuals with private employer-sponsored health insurance at a self-insured firm were insured for the costs of inpatient mental health care.

Nearly all individuals with health insurance had at least some coverage for both inpatient and outpatient mental health care. The only exception was that roughly one in 20 individuals covered by employer-sponsored plans did not have mental health benefits of any kind. Moreover, roughly one in 10 individuals covered by plans sponsored by small firms (fewer than 50 employees) had no mental health benefits.

### **D. Total Population With Mental Health Insurance**

The number of individuals in the U.S. population with mental health insurance coverage is estimated as the product of Table II.1 (the proportion of the population with health insurance) and Table II.2 (the proportion of those with health insurance and mental health benefits). At least 90 percent of those in the U.S. population who had health insurance had mental health benefits as a compo-

nent of that insurance—approximately 76 percent of the total U.S. population (Table II.3).

Eighteen percent of the population had no mental health insurance, either because they had no health insurance (15.4 percent), or because their health insurance did not provide mental health benefits (2.4 percent). It is impossible to tell whether an additional 6.5 percent had mental health benefits, because data were not available for individuals covered under an individual policy, were non-working but had employer-sponsored insurance, or were covered from a source outside the household. The figures for inpatient mental health benefits and outpatient mental health benefits are nearly identical.

The proportion of the population with mental health coverage varied moderately from state to state. In 1999, the proportion of individuals with mental health insurance ranged from a high of 82.0 percent in Minnesota, 82.9 percent in Massachusetts, and 81.9 percent in Hawaii to a low of 68.6 percent in California, 68.7 percent in Texas, and 69.3 percent in Louisiana (Table II.4). The primary reason for the state-to-state variation was the proportion of the population in each state without health insurance. Rates of uninsurance ranged from a low of 7.6 percent in Minnesota, 8.3 percent in Indiana, and 8.6 percent in Missouri to a high of 23.3 percent in Texas, 22.5 percent in Louisiana, and 21.0 percent in Arizona.

**Table II.2. Percentage of Health Insurance Covered Lives With Inpatient and Outpatient Mental Health Benefits, by Source, 1999**

| Primary Source of Health Coverage            | Percent of Covered Lives With Mental Health Benefits |                     |
|--|--|---------------------|
|  | Inpatient Benefits                                   | Outpatient Benefits |
| Medicare                                     | 100  | 100                 |
| Medicaid                                     | 100  | 100                 |
| SCHIP  |  |                     |
| M-SCHIP                                      | 100  | 100                 |
| S-SCHIP                                      | 100  | 100                 |
| Federal Employee Health Benefit Plan (FEHBP) | 100  | 100                 |
| State/Local Government Employer Plans        | 98.3   | 98.3                |
| Private, Employer-Sponsored                  |  |                     |
| Self-Insured                                 | 95.8   | 96                  |
| Fewer than 50 employees                      | 89.9   | 89                  |
| 50 or more employees                         | 96.3   | 96.6                |
| Purchased Insurance                          | 94.3   | 93.7                |
| Fewer than 50 employees                      | 90.2   | 87.9                |
| 50 or more employees                         | 96.6   | 97                  |
| Non-Working Employer-Based <sup>a</sup>      | NA   | NA                  |
| TRICARE                                      | 100  | 100                 |
| CHAMPVA                                      | 100  | 100                 |
| Veterans Affairs (VA)                        | 100  | 100                 |
| Indian Health System                         | 100  | 100                 |
| Individually Purchased                       | NA   | NA                  |
| Coverage From Outside the Household          | NA   | NA                  |

Source: March 2000 Current Population Survey conducted by the Bureau of the Census; 2000 Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC) conducted by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS).

NA = Not available.

<sup>a</sup> Primarily retired persons covered by insurance sponsored by a previous employer.

Table II.3. U.S. Population With Mental Health Insurance, 1999

| Mental Health Insurance Status                                    | Inpatient Mental Health Benefits |   |  | Outpatient Mental Health Benefits |   |
|---|----------------------------------|---|--|-----------------------------------|---|
|   | Individuals (millions)           | Proportion of U.S. Population (percent) |  | Individuals (millions)            | Proportion of U.S. Population (percent) |
| Health Insurance With Mental Health Benefits                      | 207.4                            | 75.7                                    |  | 207.1                             | 75.6                                    |
| Health Insurance Without Mental Health Benefits                   | 6.5                              | 2.4                                     |  | 6.9                               | 2.5                                     |
| Health Insurance With Unknown Mental Health Benefits <sup>a</sup> | 17.9                             | 6.5                                     |  | 17.9                              | 6.5                                     |
| No Health Insurance   | 42.3                             | 15.4                                    |  | 42.3                              | 15.4                                    |
| Total   | 274.1                            | 100                                     |  | 274.1                             | 100                                     |

Source: March 2000 Current Population Survey conducted by the Bureau of the Census; 2000 Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC) conducted by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS).

<sup>a</sup> This category represents individuals with individually purchased insurance policies, non-working individuals with employer-sponsored insurance, and individuals with health insurance through a source outside the household. No consistent information is available about the prevalence of mental health benefits in these policies.

State rates of uninsurance vary for a number of reasons. First, smaller firms were less likely to offer health benefits than larger firms (Kaiser Family Foundation and Health Research and Educational Trust, 2000) and the proportion of individuals employed by small firms varied from state to state. Second, the proportion of individuals enrolled in public insurance programs, such as Medicaid and SCHIP, varied by state due to differences in the income of the state population and state eligibility levels. Finally, states with large immigrant populations, such as California and Texas, had higher rates of uninsurance because of unique restrictions on immigrant

access to public health programs (Kaiser Family Foundation, 2000).

The percentage of individuals who had health insurance without mental health benefits varied over a much smaller range—from a low of 1.0 percent in Massachusetts, 1.3 percent in Florida and Hawaii, and 1.4 percent in Mississippi, to a high of 4.0 percent in California, 2.9 percent in Minnesota, and 2.8 percent in Colorado, Connecticut, and New Jersey. Among the factors behind this variation were the proportion of the population covered by private employer-sponsored insurance, the state rate of self-insurance, and the rate of enrollment in Federal programs.

**Table II.4. Proportion of Population With Mental Health Insurance, by State, 1999 (Percentages)**

| State                | Health Insurance With Mental Health Benefits | Health Insurance Without Mental Health Benefits | No Health Insurance |
|----------------------|--|---|---------------------|
| Alabama              | 76   | 2.3   | 14.3                |
| Alaska               | NA   | NA  | NA                  |
| Arizona              | 69.3   | 2   | 21                  |
| Arkansas             | NA   | NA  | NA                  |
| California           | 68.6   | 4   | 20.3                |
| Colorado             | 73.7   | 2.8   | 16.8                |
| Connecticut          | 81.4   | 2.8   | 9.8                 |
| Delaware             | NA   | NA  | NA                  |
| District of Columbia | NA   | NA  | NA                  |
| Florida              | 72.8   | 1.3   | 19.2                |
| Georgia              | 75.2   | 2.3   | 16.1                |
| Hawaii               | 81.9   | 1.3   | 11.1                |
| Idaho                | NA   | NA  | NA                  |
| Illinois             | 78   | 2.7   | 14.1                |
| Indiana              | 79.7   | 2.7   | 10.8                |
| Iowa                 | 80.7   | 2.8   | 8.3                 |
| Kansas               | 77   | 2.6   | 12.1                |
| Kentucky             | 78.4   | 2.5   | 14.5                |
| Louisiana            | 69.3   | 2   | 22.5                |
| Maine                | 78.1   | 2.5   | 11.9                |
| Maryland             | 79.8   | 2.5   | 11.8                |
| Massachusetts        | 82.9   | 1   | 10.5                |
| Michigan             | 80.4   | 2.8   | 11.2                |
| Minnesota            | 82   | 2.9   | 7.6                 |
| Mississippi          | 75.8   | 1.4   | 16.6                |
| Missouri             | 81   | 2.6   | 8.6                 |
| Montana              | 71.4   | 2.2   | 15.6                |
| Nebraska             | 76.1   | 2.4   | 10.8                |
| Nevada               | NA   | NA  | NA                  |
| New Hampshire        | NA   | NA  | NA                  |
| New Jersey           | 77.5   | 2.8   | 13.4                |
| New Mexico           | NA   | NA  | NA                  |
| New York             | 76.4   | 1.5   | 16.4                |
| North Carolina       | 75.4   | 2.4   | 15.4                |
| North Dakota         | NA   | NA  | NA                  |
| Ohio                 | 80.4   | 2.6   | 11                  |
| Oklahoma             | 76.1   | 2.2   | 15.3                |

**Table II.4. Proportion of Population With Mental Health Insurance, by State, 1999 (Continued)**

| State          | Health Insurance With Mental Health Benefits | Health Insurance Without Mental Health Benefits | No Health Insurance |
|----------------|--|---|---------------------|
| Oregon         | 76   | 2.7   | 14.3                |
| Pennsylvania   | 80.6   | 2.7   | 9.4                 |
| Rhode Island   | NA   | NA  | NA                  |
| South Carolina | 74.2   | 2.2   | 17.6                |
| South Dakota   | NA   | NA  | NA                  |
| Tennessee      | 78.9   | 2.3   | 11.4                |
| Texas          | 68.7   | 2.2   | 23.3                |
| Utah           | NA   | NA  | NA                  |
| Vermont        | 81.9   | 2.6   | 12.3                |
| Virginia       | 77.5   | 2.3   | 14.1                |
| Washington     | 75.7   | 2.4   | 15.2                |
| West Virginia  | NA   | NA  | NA                  |
| Wisconsin      | 78.2   | 2.6   | 10.8                |
| Wyoming        | NA   | NA  | NA                  |
| All States     | 75.7   | 2.4   | 15.4                |

Source: March 2000 Current Population Survey conducted by the Bureau of the Census; 2000 Insurance Component of the Medical Expenditure Panel Survey (MEPS-IC) conducted by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS).

NA = The MEPS-IC sample was too small to prepare statistically reliable estimates for the state.

Note: Individuals residing in areas where the presence of mental health benefits is unknown are not presented in this table.

## E. Summary

Approximately 76 percent of the U.S. population had mental health benefits in 1999. The lack of health insurance was the most significant reason why an individual did not have mental health benefits. Even at the state level, differences in the percentage of individuals with mental health coverage primarily were driven by differences in state rates of health insurance coverage. Approximately nine out of 10 individuals with health insur-

ance had mental health benefits as part of their coverage. Nearly all public insurance sources and the overwhelming majority of private, employer-sponsored health insurance plans covered mental health benefits. However, little is known about mental health benefits among some subgroups of coverage. For instance, no information is available on the prevalence of mental health benefits in individual insurance plans or in health plans for retirees.







# Generosity of Mental Health Benefits

This chapter provides estimates of the proportion of individuals who have mental health benefits that meet or exceed a benchmark level of generosity, or that meet a common level of mental health coverage. Wherever possible, generosity of mental health benefits refers to one of the following: 1) benefits that meet or exceed the benchmark level of coverage; 2) benefits that are less than the benchmark; or 3) benefits that are not included in health insurance coverage.

The benchmark level of generosity for mental health insurance benefits is coverage of 30 inpatient days, 20 outpatient visits, and prescription drugs. This level was chosen to represent the level of coverage typical of many health plans and is not intended as a measure of plan adequacy.

Utilization limits for the benchmark were selected based on three pieces of evidence. The first was the advice of an expert advisory panel (the members of which are listed in Appendix C) on the typical provisions of employer-sponsored mental health insurance benefits in 1999. The second was the Mercer Worldwide Survey of Employer-Sponsored Health Insurance Plans, which indicated the typical mental health insurance plan in 1999 covered 30 inpatient days and 20 outpatient visits (see Appendix B). A third indicator was the Federal Employee Health Benefit Plan (FEHBP) requirement that all contracting health plans cover a minimum 30 inpatient mental health days and 20 outpatient mental health visits in 1999.

In addition to utilization limits, prescription drug coverage was included in the benchmark benefit package. Prescription drugs are now a primary form of treatment for many mental illnesses. In 1997, prescription drugs accounted for almost 13 percent of total mental health care spending (Mark, 2000). Prescription drug coverage also is considered “standard” in the employer-sponsored health insurance market (Kaiser Family Foundation, 2000). Cost sharing and dollar limits were not included in the definition of benefit generosity since these measures vary considerably among health plans. Additionally, this definition of generosity only examines the availability of mental health benefits, not the affordability.

## A. Generosity of Mental Health Benefits, by Source of Coverage

Although the most recent research on the generosity of mental health benefits has focused on private, employer-sponsored plans, this chapter provides a more compre-

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hensive review of the generosity of mental health benefits from all major payors, including benefits available to Medicare beneficiaries, Federal employees, SCHIP and Medicaid enrollees, individuals receiving care in the military and veterans' health systems, and the Indian Health Service (see Table III.1). Several public providers of health insurance, such as Medicaid and Medicare, are major payors of mental health care, and the generosity of their coverage has significant implications for the extent and breadth of mental health coverage in the United States.

### *1. Private, Employer-Sponsored Insurance*

In 1999, approximately 59 percent of individuals with private, employer-sponsored health insurance provided through a firm with 10 or more employees had mental health coverage that at least met the benchmark (see Table III.2). The remaining individuals either had mental health benefits that fell below the benchmark (36 percent), or they had no mental health benefits at all (4 percent).

Estimates for the private, employer-sponsored health insurance market were derived from the Mercer Worldwide Survey of Employer-Sponsored Health Plans. The Mercer survey provides no specific information on benefit limits for medical/surgical services for those health plans indicating parity in mental health benefits. The survey did not identify plans offering mental health benefits that were at parity but that did not meet

the generosity standard. This study assumes all plans with mental health benefits at parity had mental health benefits that met the benchmark standard.

The generosity of mental health benefits varied with firm size. The percentage of individuals with mental health benefits meeting the benchmark increased as firm size increased. Only 46 percent of individuals with employer-sponsored health insurance in a firm with 10–49 employees had mental health benefits that met the benchmark, but the number increased to 67 percent for individuals who had employer-sponsored health insurance in a firm with 500 or more employees.

### *2. Medicare*

The traditional Medicare benefit package does not meet the benchmark benefit since it lacks prescription drug coverage, a major component of today's mental health care. However, approximately 62 percent of Medicare beneficiaries in 1999 had some prescription drug coverage through supplemental insurance, including a Medicare HMO, Medicaid, or an employer-sponsored retirement plan (Laschober et al., 2002). Therefore, Medicare beneficiaries with prescription drug coverage through supplemental insurance were counted as having mental health insurance that meets the benchmark standard (see Table III.3).

Table III.1. Public Sources of Mental Health Insurance in 1999

| Program  | Benefit Summary   | Relationship to Benchmark Benefit   |
|--|---|---|
| <b>Medicare</b>  | Inpatient: 190-day lifetime limit on psychiatric hospital days, same as medical benefit for psychiatric care in general hospital. Cost sharing same as medical benefit. Outpatient: No limit on utilization. Most mental health doctor and professional services have 50 percent co-insurance compared with medical services that have 20 percent co-insurance. Also covers partial hospitalization and occupational therapy. | Does not meet benchmark due to lack of prescription drug benefit; however, many beneficiaries have prescription drug coverage through supplemental insurance (see text and Appendix A). |
| <b>Medicaid</b><br>Children 0 to 21 years of age         | Technically, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirement provides for all medically necessary inpatient and outpatient care in all states. <sup>a</sup> Optional services that may be part of a state plan include residential care, partial hospitalization, clinic services, and case management.  | Meets benchmark.  |
| Adults 22 years and older                                | Benefit varies by state, but generally includes physician services, outpatient hospital services, partial hospitalization, rehabilitative services, and occupational therapy. Federal exclusion of inpatient care provided in Institutions for Mental Disease (IMDs) generally precludes care in psychiatric hospitals. However, states provide inpatient psychiatric care in general acute hospitals.                        | Six states do not appear to meet benchmark because of utilization limitations (see text).   |
| <b>SCHIP<sup>b</sup></b><br>Medicaid Expansion (M-SCHIP) | Same benefit as that available in state Medicaid program.   | Meets benchmark.  |
| Separate Program Expansion (S-SCHIP)                     | Benefits vary by state but generally just cover inpatient and outpatient services. (Appendix D).  | Two of 33 states with S-SCHIP program do not meet benchmark (Montana and New Hampshire).  |

Source: Program information materials.

<sup>a</sup> Many states are not yet in full compliance with EPSDT requirements; however, all children technically are eligible for such services.

<sup>b</sup> In 1999, only children were enrolled in SCHIP. Since that time, some states have allowed adults to enroll.

Table III.1. Public Sources of Mental Health Insurance in 1999 (Continued)

| Program  | Benefit Summary   | Relationship to Benchmark Benefit |
|--|---|-----------------------------------|
| <b>Federal Employee Health Benefit Program<sup>a</sup></b>                                 | Inpatient: Minimum benefit of 30 mental health days per year at 50 percent cost sharing. Outpatient: Minimum benefit of 20 outpatient mental health visits per year at 50 percent cost sharing.   | Meets benchmark benefit.          |
| <b>TRICARE</b>   | Inpatient: Generally, for children under age 19, 45 inpatient mental health days per year. For adults, 30 inpatient mental health days per year. Outpatient: Approval needed for more than eight visits per fiscal year. Partial hospitalization limited to 60 days per year. Cost sharing for inpatient and outpatient services depends on eligibility category and whether individual is enrolled in TRICARE Prime, Standard, or Extra. | Meets benchmark benefit.          |
| <b>Veterans Affairs (VA)</b>   | No limits on inpatient or outpatient services. Also covers rehabilitative services, partial hospitalization, and preventive services. Cost-sharing the same as for medical services.  | Meets benchmark benefit.          |
| <b>Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)</b> | Inpatient: 45 inpatient mental health days per year for children, 30 inpatient days per year for adults. Outpatient: 23 outpatient visits per year. Also covers crisis intervention and 60 days per year of partial hospitalization. Cost sharing is same as for medical benefits.  | Meets benchmark plan.             |
| <b>Indian Health Service (IHS)</b>   | No special limits.  | Meets benchmark plan.             |

Source: Program information materials.

<sup>a</sup> Many states are not yet in full compliance with EPSDT requirements; however, all children technically are eligible for such services.

<sup>b</sup> In 1999, only children were enrolled in SCHIP. Since that time, some states have allowed adults to enroll.

<sup>c</sup> In 2001, FEHBP mandated mental health parity for all participating health plans.

**Table III.2. Generosity of Mental Health Benefits Among Individuals With Private, Employer-Sponsored Insurance Provided by Firms With 10 or More Employees, 1999**

| Firm Size                                 | Total Population (millions) | Percent With Benefits at Least Meeting Benchmark | Percent With Mental Health Benefits Less Than Benchmark | Percent With Health Insurance But No Mental Health Benefits |
|---|-----------------------------|--|---|---|
| 10 to 49 Employees                        | 17.3                        | 45.8   | 45.9  | 8.3   |
| 50 to 499 Employees                       | 28.8                        | 54.1   | 40.9  | 5.1   |
| 500 to 999 Employees                      | 8                           | 55.3   | 42  | 2.7   |
| 1,000 or More Employees                   | 54.4                        | 67   | 30.1  | 2.8   |
| Total for Firms With 10 or More Employees | 108.5                       | 59.3   | 36.4  | 4.3   |

Source: Mercer Worldwide Survey of Employer-Sponsored Health Plans combined with the March 2000 Current Population Survey, conducted by the Bureau of the Census.

Note: The Mercer Worldwide survey does not include the smallest firms (nine or fewer employees); therefore, there is no information on the extent of their mental health coverage. Approximately 12.5 million individuals receive health insurance through these very small firms.

### 3. Medicaid

Under the Federal early and periodic screening, diagnosis, and treatment (EPSDT) requirement, children enrolled in Medicaid with an identified mental disorder are eligible to receive an unlimited amount of medically necessary mental health services, including inpatient days, outpatient visits, and prescription drugs. For this reason, all Medicaid-enrolled children are categorized as receiving mental health benefits meeting the benchmark standards. However, state implementation of and adherence to EPSDT standards varies. A recent report issued by the U.S. General Accounting Office (GAO) stated, “The extent to which children in Medicaid across the country are receiving EPSDT serv-

ices is not fully known, but the available evidence indicates that many are not receiving these services” (U.S. General Accounting Office, 2001). Absent quantitative evidence about the number of Medicaid-enrolled children receiving EPSDT services, all children are counted as having access to such services.

With regard to adult beneficiaries, an examination of state Medicaid plans revealed six states in which the Medicaid benefit package for adults between the ages of 22 and 64 years does not appear to meet the benchmark of 30 inpatient mental health days, 20 outpatient mental health visits, and prescription drug coverage (Commerce Clearing House, see dates below).

**Table III.3. Generosity of Mental Health Benefits Among Those With Health Insurance, 1999**

| Individuals With Health Insurance Through:      | Total Insured Population (millions) | Benefits at Least Meeting Benchmark (percent) | Mental Health Benefits Less Than Benchmark (percent) | Mental Health Benefits of Unknown Generosity (percent) | Health Insurance But No Mental Health Benefits (percent) | Health Insurance With Unknown Mental Health Benefits (percent) |
|---|-------------------------------------|---|--|--|--|--|
| Employer-Sponsored Insurance Through a Firm of: |                                     |   |  |  |  |  |
| 1 to 9 Employees                                | 12.5                                | N/A   | N/A  | 87.1   | 12.9   | 0  |
| 10 or more Employees                            | 108.5                               | 59.3  | 36.4   | 0  | 4.3  | 0  |
| Non-Working Employer-Based                      | 3.7                                 | N/A   | N/A  | N/A  | N/A  | 100  |
| Medicare  | 36.1                                | 62.3  | 37.7   | 0  | 0  | 0  |
| Medicaid  |                                     |   |  |  |  |  |
| Children birth to 17 years                      | 12.2                                | 100   | 0  | 0  | 0  | 0  |
| Adults 18 years or older <sup>a</sup>           | 9                                   | 94.1  | 5.9  | 0  | 0  | 0  |
| SCHIP <sup>b</sup>                              |                                     |   |  |  |  |  |
| M-SCHIP   | 0.7                                 | 100   | 0  | 0  | 0  | 0  |
| S-SCHIP   | 1.3                                 | 99.7  | 0.4  | 0  | 0  | 0  |
| Federal Employee Health Benefit Plan (FEHBP)    | 5.2                                 | 100   | 0  | 0  | 0  | 0  |
| State/Local Government                          | 22.5                                | N/A   | N/A  | 98.3   | 1.7  | 0  |
| TRICARE   | 4.9                                 | 100   | 0  | 0  | 0  | 0  |
| CHAMP/VA  | 0.3                                 | 100   | 0  | 0  | 0  | 0  |
| Veterans Affairs (VA)                           | 0.5                                 | 100   | 0  | 0  | 0  | 0  |
| Indian Health System (IHS)                      | 0.3                                 | 100   | 0  | 0  | 0  | 0  |
| Individual Purchased                            | 9.6                                 | N/A   | N/A  | N/A  | N/A  | 100  |
| Coverage From Outside the Household             | 4.6                                 | N/A   | N/A  | N/A  | N/A  | 100  |
| Total   | 231.9                               | 52.1  | 23.1   | 14.2   | 2.9  | 7.7  |

Source: Mathematica Policy Research, Inc. (MPR) calculations based on the Current Population Survey, the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), the Mercer Worldwide Survey of Employer-Sponsored Health Plans, and program information materials.

N/A: Not Available

<sup>a</sup> All states were considered to meet the benchmark except Alabama, Arkansas, Mississippi, Oklahoma, West Virginia, and Wyoming. Estimates of the percentage of adult Medicaid recipients from these states were derived from CMS's Medicaid enrollment files for 1999.

<sup>b</sup> Enrollment information for M-SCHIP and S-SCHIP programs is from Centers for Medicare and Medicaid Services (2000b). Benefit information for S-SCHIP programs is from the National Conference of State Legislatures (2001) and does not include cost sharing (see Appendix D).

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Alabama has a limit of 16 inpatient hospital days per year for both physical and mental conditions. The state also limits outpatient psychotherapy to 14 visits per year; it is unclear whether individuals could circumvent the limit by using clinics. The limit on psychotherapy is part of an overall 14-visit limit for all physician services (October 23, 2001).

Arkansas limits adults to 24 inpatient hospital days per year for physical and mental health conditions. The state also limits outpatient visits to 12 per year for all physician services. The state plan does not cover psychologist services for adults (April 6, 1999).

Mississippi limits total outpatient physician services to 12 per year. Psychiatric services by a physician are limited to 10 individual medical psychotherapy sessions and six group medical psychotherapy sessions (September 18, 2001).

With the exception of enrollees in SoonerCarePlus, a Medicaid managed care program in Oklahoma City, Oklahoma, Medicaid enrollees are subject to an inpatient hospital limit of 24 days per year total for physical and mental conditions (April 16, 2002).

West Virginia limits inpatient care to 25 days per year for all conditions (December 31, 2001).

Wyoming has a limit of 12 visits per year on all outpatient services for adults in its Medicaid program (December 18, 2001).

The Institution for Mental Diseases (IMD) exclusion prohibits states from receiving Federal reimbursement for Medicaid patients aged 22 to 64 years in IMDs, although states may add inpatient services in an IMD as an optional service for the elderly population. However, Medicaid programs generally provide inpatient psychiatric services to adult enrollees through general hospitals.

#### **4. SCHIP**

State SCHIP programs are of three types: a Medicaid expansion (M-SCHIP), a separate program (S-SCHIP), or a combination of the two. SCHIP enrollees in an M-SCHIP program are entitled to the same benefits available under the Medicaid program. In 1999, approximately 700,000 children were enrolled in an M-SCHIP program.

For states that choose to implement an S-SCHIP program, benefits can be quite different from those available in the state Medicaid program. The Federal government requires only that state S-SCHIP benefit packages be comparable to one of the following benchmark plans: the FEHBP standard option plan, the state's employee health benefit plan, the health maintenance organization with the largest commercially enrolled population in the state, or another package approved by the Federal government.

Specific to mental health benefits, the S-SCHIP program must include coverage that is at least 75 percent of the actuarial value of selected plans (Center for Mental Health Services, 2000). Benefit limits are common among the 33 states using the S-SCHIP option (see Appendix D). Of the 33 states with S-SCHIP programs, 10 have no limits on mental health benefits (two additional states have at least one S-SCHIP plan option with no limits on mental health benefits), another 21 have benefit limits that meet or exceed the benchmark, and two (Montana and New Hampshire) have mental health benefits below the benchmark.

In 1999, approximately 5 percent of S-SCHIP enrollees were in a plan with no limits on mental health coverage and just fewer than 95 percent were in a plan with limits that nonetheless met the benchmark benefit. Fewer than 1 percent of S-SCHIP enrollees

were in the two states with a benefit package below the benchmark.

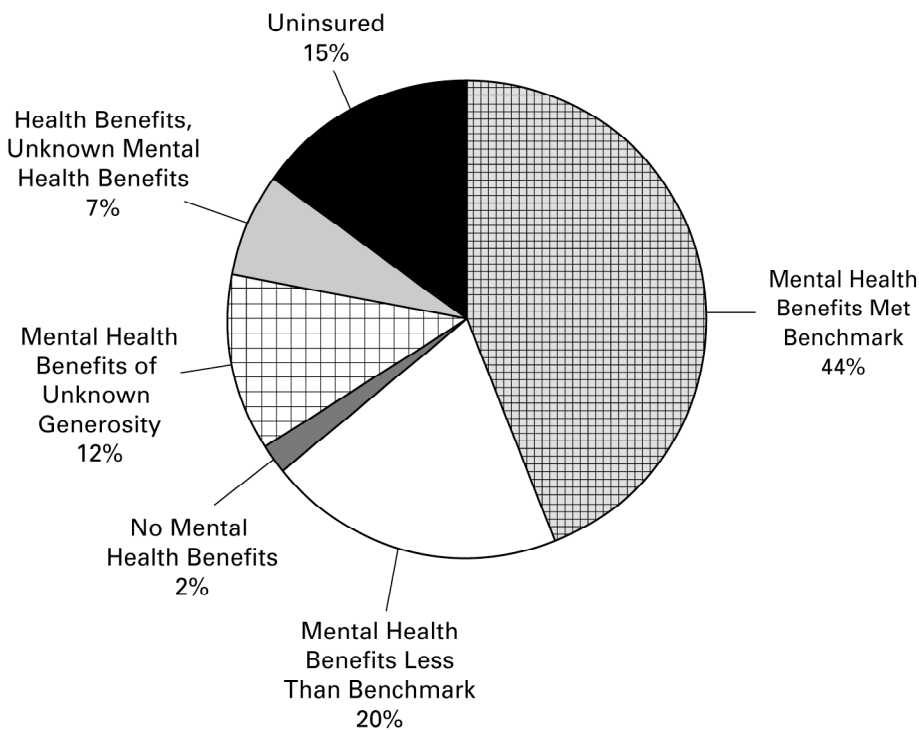
##### 5. Other Sources of Health Insurance

In 1999, the mental health benefit packages in FEHBP, TRICARE, and CHAMPVA met the benchmark criteria. Although an estimated 98 percent of individuals with health insurance sponsored by state and local governments have mental health benefits, comprehensive

data on the generosity of coverage of those plans is not available.

No information on mental health benefits, including whether mental health conditions are covered, is available for retired individuals with insurance from their previous employer (3.7 million), individuals with insurance from a source outside the household (4.6 million), or those with individually purchased health insurance policies (9.6 million).

Figure III.1 Generosity of Mental Health Benefits in Total U.S. Population, 1999



Source: MPR calculations based on data from the CPS, the MEPS-IC, Mercer Worldwide Survey of Employer-Sponsored Health Plans, and public program information materials.



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## **B. Summary**

Approximately 52 percent of individuals with health insurance had mental health benefits in 1999 that met or exceeded the benchmark package (Table III.3). However, when the uninsured are included, the percentage of individuals with mental health insurance in 1999 that met or exceeded the benchmark drops to approximately 44 percent of the entire U.S. population (see Figure III.1). Approximately 20 percent of the U.S. popu-

lation had mental health benefits that did not meet the benchmark, and at least another 2 percent had health insurance that did not cover mental health services at all. For an additional 19 percent, insufficient data prevented estimates of the generosity of their mental health benefits: 12 percent had mental health benefits of unknown generosity, and 7 percent had health benefits, but with unknown mental health benefits. The remaining 15 percent were uninsured.



# IV.

# Parity in Mental Health Benefits

This section presents estimates of the number of individuals with parity in mental health benefits and those potentially subject to parity laws. Full financial parity requires mental health benefits to be the same as medical and surgical benefits in relation to dollar limits, utilization limits, and cost-sharing requirements, if mental health services are covered. It is possible that a benefit package can meet the requirements of parity without meeting the benchmark benefit package discussed earlier. For example, a health plan could have a 20-day limit on inpatient hospital care for both medical and mental health stays, qualifying the plan for parity coverage without meeting the benchmark.

Following a discussion of the number of individuals reporting parity in mental health benefits in 1999, the focus turns to mental health parity laws—one way in which both Federal and state governments have acted to ensure access to mental health benefits. Estimates of the number of individuals in 1999 covered by state mental health parity laws and the now sunsetted Federal Mental Health Parity Act of 1996 (MHPA) are provided.

## **A. Individuals With Parity in Mental Health Benefits in 1999**

Most research concerning parity in mental health coverage has focused on the private, employer-sponsored market, excluding many public programs. This section describes the mental health benefits available from all insurers in relation to full financial parity.

### *1. Private, Employer-Sponsored Health Insurance*

In 1999, approximately 14 percent of individuals with private, employer-sponsored health insurance provided through a firm with 10 or more employees had full parity in their mental health benefits (see Table IV.1). Parity in mental health benefits, as well as generosity of mental health benefits, varies by firm size. As firm size increases, generosity of benefits increases, but the reverse is true for mental health parity. As firm size increases, firms are less likely to provide parity in mental health benefits.

Approximately 23 to 24 percent of individuals who received health insurance through a firm of 10 to 499 employees had mental health benefits equal to those of their medical benefits. In contrast, just 6 to 8 percent of individuals with health insurance through a firm of 500 or more employees had full mental health parity.

**Table IV.1. Full, Financial Parity in Mental Health Benefits Among Individuals With Private, Employer-Sponsored Insurance Provided By Firms With 10 or More Employees, 1999**

| Firm Size                                 | Total Population (millions) | Percentage With Parity in Mental Health Benefits | Percentage With Mental Health Benefits Less Than Parity | Percentage With Health Insurance But No Mental Health Benefits |
|---|-----------------------------|--|---|--|
| 10 to 49 Employees                        | 17.3                        | 24.2   | 67.5  | 8.3  |
| 50 to 499 Employees                       | 28.8                        | 22.5   | 72.5  | 5.1  |
| 500 to 999 Employees                      | 8                           | 6.2  | 91.1  | 2.7  |
| 1,000 or More Employees                   | 54.4                        | 8.2  | 88.9  | 2.8  |
| Total for Firms With 10 or More Employees | 108.5                       | 14.4   | 81.3  | 4.3  |

Source: Mercer Worldwide Survey of Employer-Sponsored Health Plans combined with March 2000 Current Population Survey, conducted by the Bureau of the Census.

One possible explanation for the fact that larger firms are less likely to provide parity in mental health benefits has to do with whether health plans are self-insured. Buck et al. (1999) found that self-insured plans are less likely to have mental health benefits on par with medical/surgical benefits. Under the Employment Retirement Income Security Act of 1974 (ERISA), self-insured plans are not subject to state mental health parity laws. Since fewer small firms are self-insured, smaller firms are more likely to be subject to state parity laws. However, although more small firms may offer parity in mental health benefits, it should be noted that the percentage of small firms that do not provide mental health benefits at all is higher than that of large firms.

## 2. Federal Public Programs

Coverage of mental health benefits in public programs varies considerably. Although many of the programs cover mental health benefits

at parity with medical/surgical benefits, some important exceptions are noted. Table IV.2 briefly describes the benefits in Federal and state programs and whether the benefits achieve parity.

Medicare, which covered roughly 36 million individuals in 1999, does not offer parity in mental health benefits. Although most outpatient services require 20 percent patient cost sharing, mental health outpatient services have 50 percent cost sharing. Medicaid, the Nation's program for the poor and disabled, does offer parity in mental health benefits, despite the limitation that inpatient psychiatric care be provided in general hospitals. However, states opting to offer S-SCHIP programs can, and often do, offer benefit packages that provide less mental health coverage than is available under Medicaid. Ten of the 33 state S-SCHIP programs, which represent just 5 percent of S-SCHIP enrollees, provide parity in mental health coverage. (Two additional states have one or more plan options at parity.)

**Table IV.2. Parity of Mental Health Coverage in Public Sources of Mental Health Insurance, 1999**

| Program  | Benefit Summary  | Relationship to Full Parity   |
|--|--|---|
| <b>Medicare</b>  | Inpatient: 190-day lifetime limit on psychiatric hospital days, same as medical benefit for psychiatric care in general hospital. Cost sharing same as medical benefit.<br>Outpatient: No limit on utilization. Most mental health physician and professional services have 50 percent co-insurance, compared with medical services that have 20 percent co-insurance. Also covers partial hospitalization and occupational therapy. | Does not meet parity due to differential cost sharing requirement for outpatient mental and medical services. |
| <b>Medicaid</b><br>Children 0 to 21 years of age                   | Technically, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirement provides for all medically necessary inpatient and outpatient care in all states. <sup>a</sup> Optional services that may be part of a state's plan include residential care, partial hospitalization, clinic services, and case management.   | Meets parity requirement.   |
| Adults 22 years and older  | Benefit varies by state but generally includes physician services, outpatient hospital services, partial hospitalization, rehabilitative services, and occupational therapy. Federal exclusion of inpatient care provided in Institutions for Mental Diseases (IMDs) generally precludes care in psychiatric hospitals. However, states provide inpatient psychiatric care in general acute hospitals.                               | Meets parity requirement.   |
| <b>SCHIP<sup>b</sup></b><br>Medicaid Expansion<br>(M-SCHIP)        | Same benefit as available in state Medicaid program.   | Meets parity requirement.   |
| Separate Program Expansion (S-SCHIP)                               | Benefits vary by state but generally just cover inpatient and outpatient services (Appendix D).  | Twenty-three of 33 states with S-SCHIP program do not meet parity requirement.                                |
| <b>Federal Employee Health Benefit Program (FEHBP)<sup>c</sup></b> | Inpatient: Minimum benefit of 30 mental health days per year at 50 percent cost sharing. Outpatient: Minimum benefit of 20 outpatient mental health visits per year at 50 percent cost sharing.  | Minimum benefit does not meet parity requirement.   |

Table IV.2. Parity of Mental Health Coverage in Public Sources of Mental Health Insurance, 1999 (Continued)

| Program  | Benefit Summary   | Relationship to Full Parity  |
|--|---|--|
| <b>TRICARE</b>   | Inpatient: Generally, for children under age 19, 45 inpatient mental health days per year. For adults, 30 inpatient mental health days per year. Outpatient: Approval needed for more than eight visits per fiscal year. Partial hospitalization limited to 60 days per year. Cost sharing for inpatient and outpatient services depends on eligibility category and whether individual is enrolled in TRICARE Prime, Standard, or Extra. | Does not meet parity due to utilization limits for inpatient mental health and differential cost sharing for some eligible groups. |
| <b>Veterans Affairs (VA)</b>   | No limits on inpatient or outpatient services. Also covers rehabilitative services, partial hospitalization, and preventive services. Cost-sharing the same as for medical services.  | Meets parity requirement.  |
| <b>Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)</b> | Inpatient: 45 inpatient mental health days per year for children, 30 inpatient days per year for adults. Outpatient: 23 outpatient visits per year. Also covers crisis intervention and 60 days per year of partial hospitalization. Cost sharing is same as for medical benefits.  | Does not meet parity requirement due to utilization limits.  |
| <b>Indian Health Service (IHS)</b>   | No special limits.  | Meets parity requirement.  |

Source: Program information materials.

<sup>a</sup> Many states are not yet in full compliance with EPSDT requirements; however, all children are technically eligible for such services.

<sup>b</sup> In 1999, only children were enrolled in SCHIP. Since that time, some states have allowed adults to enroll.

<sup>c</sup> In 2001, FEHBP mandated mental health parity for all participating health plans.

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FEHBP did not require its contractors to provide parity in mental health benefits in 1999, although it since has adopted a full financial mental health parity policy. Two other programs that do not have parity in mental health benefits are TRICARE and CHAMPVA.

### **3. Other Sources of Health Insurance**

Although it is estimated that 98 percent of individuals with health insurance sponsored by state and local governments have mental health benefits, comprehensive data on the generosity of coverage in state and local plans are not available. In 1999, two states, North Carolina and Texas, required full mental health parity for state employees. Since 1999, Indiana (2000) and South Carolina (2002) also have required full parity in their state employee health plans.

No information on mental health benefits, including whether mental conditions are covered, is available for retired individuals with insurance from their previous employer (3.7 million), individuals with insurance from a source outside the household (4.6 million), or those with individually purchased health insurance policies (9.6 million).

### **4. Estimates of Number of Individuals With Full Financial Parity in Mental Health Benefits**

Nearly 38 percent of individuals with health insurance had full financial parity in mental health benefits in 1999 (see Table IV.3). The private, employer-sponsored health insurance market and Medicaid were the two foremost insurers offering parity in benefits. Another 38 percent of those with health insurance did not have equal mental health and medical benefits. Many of these individuals received their insurance through public sources,

including Medicare, S-SCHIP, and TRICARE. At least 3 percent of individuals with health insurance had no mental health benefits. Insufficient data prevented estimates of mental health parity in the remaining 21 percent of individuals with health insurance, including those with mental health benefits of unknown generosity (14 percent), and those with insurance whose health benefits, including coverage of mental health services, was unknown. Figure IV.1 provides a picture of parity in mental health coverage among the entire U.S. population, including those who were uninsured.

## **B. State Mental Health Parity Laws**

A number of states have enacted laws that require full mental health parity. All of the state laws apply to the private, employer-sponsored health insurance market; some states also require parity in the individual market. Parity laws vary significantly in scope and application, but full parity requires mental health benefits to be the same as medical and surgical benefits with respect to dollar limits, utilization limits, and cost-sharing requirements, if covered. As of 2002, 24 states had enacted laws that meet the definition of full mental health parity (National Conference of State Legislatures, 2001; National Alliance for the Mentally Ill, 2002).

### **1. Exemptions From State Parity Laws**

A number of factors limit the number of insurers subject to state mental health parity laws, in effect limiting the number of individuals protected by these laws. Most state parity laws focus on the private employer-sponsored insurance market, but even within this market, states are not able to require all insurers to comply with parity laws.

**Table IV.3. Financial Parity in Mental Health Benefits Among Those With Health Insurance, 1999**

| Individuals With Health Insurance Through:   | Total Insured Population (millions) | Parity in Mental Health Benefits (percent) | Mental Health Benefits Less Than Parity (percent) | Mental Health Benefits of Unknown Generosity (percent) | Health Insurance But No Mental Health Benefits (percent) | Health Insurance With Unknown Mental Health Benefits (percent) |
|--|-------------------------------------|--|---|--|--|--|
| Employer-Sponsored Insurance Through         |                                     |  |   |  |  |  |
| 1 to 9 Employees                             | 12.5                                | N/A  | N/A   | 87.1   | 12.9   | 0  |
| 10 or More Employees                         | 108.5                               | 59.3                                       | 36.4  | 0  | 4.3  | 0  |
| Non-Working Employer-Based <sup>a</sup>      | 3.7                                 | N/A  | N/A   | N/A  | N/A  | 100  |
| Medicare                                     | 36.1                                | 0  | 100   | 0  | 0  | 0  |
| Medicaid                                     |                                     |  |   |  |  |  |
| Children Birth to 17 years                   | 12.2                                | 100  | 0   | 0  | 0  | 0  |
| Adults 18 years or older                     | 9                                   | 100  | 0   | 0  | 0  | 0  |
| SCHIP <sup>b</sup>                           |                                     |  |   |  |  |  |
| M-SCHIP                                      | 0.7                                 | 100  | 0   | 0  | 0  | 0  |
| S-SCHIP                                      | 1.3                                 | 5.2  | 94.8  | 0  | 0  | 0  |
| Federal Employee Health Benefit Plan (FEHBP) | 5.2                                 | 0  | 100   | 0  | 0  | 0  |
| State/Local Government                       | 22.5                                | N/A  | N/A   | 98.3   | 1.7  | 0  |
| TRICARE                                      | 4.9                                 | 0  | 100   | 0  | 0  | 0  |
| CHAMP/VA                                     | 0.3                                 | 0  | 100   | 0  | 0  | 0  |
| Veterans Affairs (VA)                        | 0.5                                 | 100  | 0   | 0  | 0  | 0  |
| Indian Health System (IHS)                   | 0.3                                 | 100  | 0   | 0  | 0  | 0  |
| Individual Purchased                         | 9.6                                 | N/A  | N/A   | N/A  | N/A  | 100  |
| Coverage From Outside the Household          | 4.6                                 | N/A  | N/A   | N/A  | N/A  | 100  |
| Total  | 231.9                               | 37.6                                       | 37.6  | 14.2   | 2.9  | 7.7  |

Source: MPR calculations based on the Current Population Survey, the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), the Mercer Worldwide Survey of Employer-Sponsored Health Plans, and program information materials.

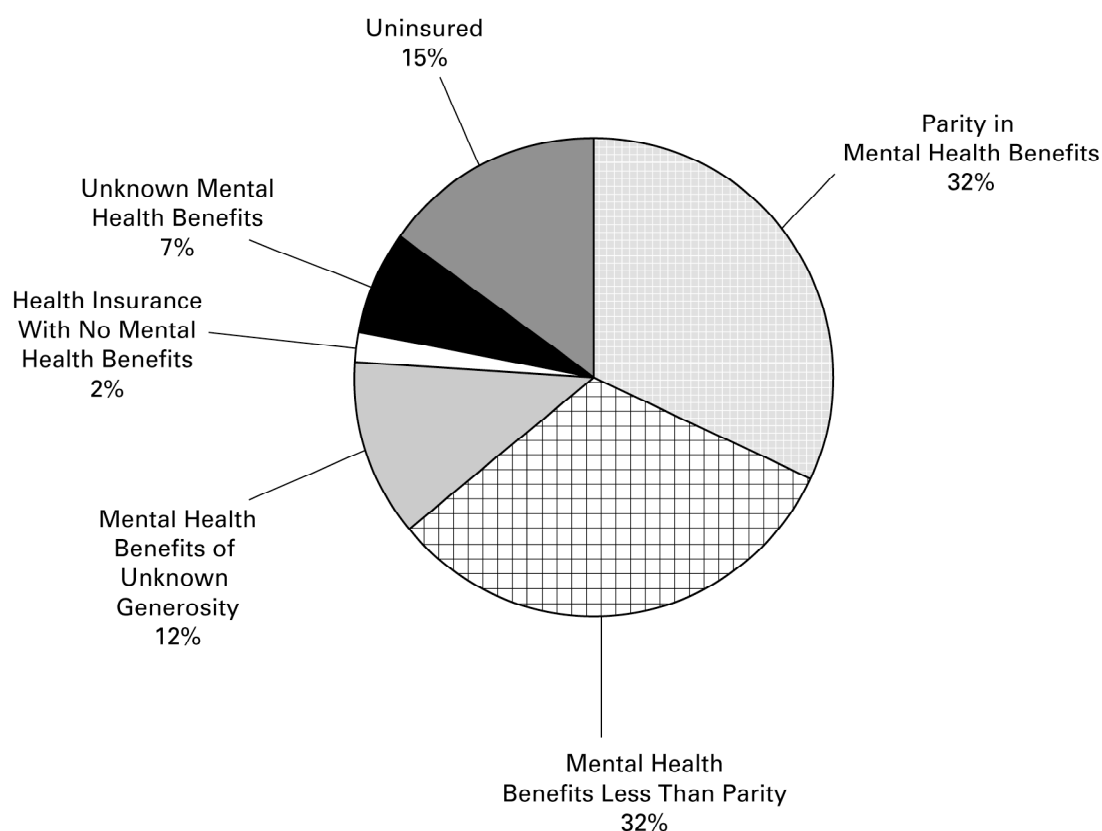
N/A: Not Available

<sup>a</sup> All states met the benchmark except Alabama, Arkansas, Mississippi, Oklahoma, West Virginia, and Wyoming. Estimates of the percentage of adult Medicaid recipients from these states were derived from CMS's Medicaid enrollment files for 1999.

<sup>b</sup> Enrollment information for M-SCHIP and S-SCHIP programs is from Centers for Medicare and Medicaid Services (2000b). Benefit information for S-SCHIP programs is from the National Conference of State Legislatures (2001) and does not include cost sharing (see Appendix D).



**Figure IV.1. Individuals in U.S. Population With Parity in Mental Health Benefits, 1999**



Source: MPR calculations based on data from the Current Population Survey, the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), the Mercer Worldwide Survey of Employer-Sponsored Health Plans, and program materials.

ERISA provides the biggest exemption of health plans from state parity laws. ERISA was enacted primarily to establish uniform standards for private employee pension plans so employers with operations in more than one state would not be forced to comply separately with each state law (Butler, 2000). In addition to employee pension plans, ERISA also covers employee health plans. ERISA prohibits states from regulating self-insured employer-sponsored health plans. A self-insured health plan is one in which the employer bears the insurance risk rather than contracting it out to a third-party insurer, such as a Blue Cross organization or an

HMO. The employer can administer self-insured plans directly or can contract out administrative services—such as setting up a provider network or conducting utilization review—to a third-party administrative services organization. As long as the employer retains the insurance risk, the health plan is considered a self-insured plan for the purposes of ERISA.

The ERISA preemption for self-insured employer-sponsored health plans means these health plans are subject only to Federal regulation. Any state regulation, such as a state parity law that goes further than the Mental Health Parity Act (MHPA), does not apply to

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these employer-sponsored plans. The estimates show that nearly 49 million individuals—approximately 39 percent of the employer-sponsored health insurance market—are in self-insured plans. Detailed state-by-state data tables on 1) health insurance by primary source and on 2) private employer-sponsored health insurance by firm size and self-insured status are available from the authors at Mathematica Policy Research, Inc. upon request. Since larger firms are in a better position to assume risk, it is not surprising that larger firms also are more likely to self-insure than smaller ones. Only about 12 percent of individuals with insurance through a firm with fewer than 50 employees were in a self-insured firm in 1999, compared with nearly 50 percent for individuals insured through a firm with 50 or more employees.

Some states either exempt small groups from compliance with parity statutes or require only partial parity for these businesses. Nine states with mental health parity laws in 2002 provided small-employer exemptions. Most states use 50 employees as the break point for small employers, but Maine uses 20 employees, while Virginia and Hawaii use 25.

Arkansas, Indiana, New Mexico, and Oklahoma have built cost exemptions into their statutes. Under these exemptions, if a plan can prove that its costs increased more than an established percentage after implementing the law, it may be exempted from the law's requirements.

## **2. Parity in 1999**

In 1999, 13 states had mental health parity laws that meet this study's definition of full

mental health parity (see Table IV.4), requiring all insurers that offer mental health benefits to apply the same annual and lifetime dollar limits, utilization limits, and cost-sharing standards to mental health benefits as those that apply to medical/surgical benefits. (Some of these states also require insurers to provide mental health benefits as part of their benefit package.) This study includes states with laws applying either to serious mental illnesses only, or to all mental illnesses. State laws that apply only to serious or biologically based mental illness typically cover schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, obsessive-compulsive disorder, and panic disorders. For states with such laws, the applicable statutes lay out the exact illnesses covered by the law, usually those illnesses delineated above. State parity laws that apply to the general category of mental illnesses usually cover any illness listed in the International Classification of Diseases Manual 9 and/or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV). (National Conference of State Legislatures, 2001; the National Alliance for the Mentally Ill, 2002).

In 1999, state mental health parity laws covered approximately 9.8 million individuals. The percentage of individuals in the private employer-sponsored market subject to state parity laws varied significantly from state to state, ranging from 39 percent in Arkansas to 67 percent in Vermont. The variation largely can be attributed to two factors: variation in the proportion of firms that self-insure, and the provision of a small-employer exemption.

**Table IV.4. States With Full Mental Health Parity Laws for the Private Group Health Insurance Market, 1999**

| State   | Year Effective | Firm Size Eligible for Small-Employer Exemption | Diseases Covered <sup>f</sup> | Estimated Number of Individuals Covered (millions) | Estimated Percentage of Individuals With Private, Employer-Sponsored Health Insurance Covered by Law |
|---|----------------|---|-------------------------------|--|--|
| <b>Estimates for States With Parity Laws Effective in 1999 and Before</b> |                |   |                               |  |  |
| Arkansas <sup>a</sup>   | 1997           | 50 or fewer                                     | MI                            | 0.4  | 39.1   |
| Colorado  | 1998           | None  | SMI                           | 1.1  | 55.4   |
| Connecticut <sup>b</sup>  | 1997           | None  | MI                            | 1.1  | 61.1   |
| Delaware <sup>a,c</sup>   | 1999           | None  | SMI                           | 0.2  | 60   |
| Hawaii <sup>d</sup>   | 1999           | 25 or fewer                                     | SMI                           | 0.2  | 40.9   |
| Maine <sup>d</sup>  | 1996           | 20 or fewer                                     | SMI                           | 0.3  | 48.9   |
| Maryland <sup>c</sup>   | 1994           | None  | MI, ED                        | 1.4  | 64.1   |
| Minnesota   | 1995           | None  | MI                            | 1.4  | 51   |
| New Hampshire <sup>a,c</sup>  | 1995           | None  | SMI                           | 0.5  | 64.7   |
| New Jersey  | 1999           | None  | SMI                           | 2.5  | 62.1   |
| Rhode Island <sup>a,e</sup>   | 1995           | None  | MI                            | 0.3  | 59.2   |
| South Dakota <sup>a,c</sup>   | 1998           | None  | SMI                           | 0.2  | 66.3   |
| Vermont   | 1998           | None  | MI                            | 0.2  | 67.2   |
| Total Across All States With Parity Laws                                  |                |   |                               | 9.8  | 57.2   |

Source: Information about state mental health parity laws comes from the National Conference of State Legislatures (2001) and the National Alliance for the Mentally Ill (2002). Information also was verified by looking up the pertinent state statutes. Estimates of the number of individuals covered by state laws are MPR calculations based on CPS estimates of the number of individuals with employer-sponsored health insurance combined with MEPS-IC calculations of the self-insured status of firms, by firm size.

<sup>a</sup> These states are among 14 states for which the MEPS-IC is unable to produce state-level estimates of the percentage of firms that were self-insured. For a rough estimate of the number of individuals covered under the state laws in these states, the national rates of self-insurance for firms with fewer or more than 50 employees can be applied to these states.

<sup>b</sup> Effective 1999, Connecticut expanded its law to cover all mental disorders. Similarly, Rhode Island expanded its law to cover all mental disorders, effective 2002.

<sup>c</sup> These states were among 11 without state-level estimates in the 1999 MEPS-IC. National estimates of the percentage of firms with 10 to 49 employees and 50 to 99 employees were applied to these states.

<sup>d</sup> These data overestimate the number of individuals exempted through the state small-employer exemption. MEPS-IC does not allow for estimates of self-insured status for firms with fewer than 25 employees. For these states, a small-employer exemption for firms with 50 or fewer employees was assumed.

<sup>e</sup> Maryland allows maximum co-insurance for outpatient mental health visits of 20 percent for visits one through five, 35 percent for visits six through 30, and 50 percent for visits 31 and over in a calendar year. Copayments cannot be higher than those for physical illnesses.

<sup>f</sup> MI: mental illnesses; SMI: serious mental illnesses or biologically based illnesses; ED: emotional disorders.

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Arkansas and Vermont, for example, illustrate both reasons for variation in the penetration rate of parity laws in the private employer-sponsored market. In Vermont, self-insured firms employ 32 percent of individuals with private employer-sponsored health insurance, compared with 41 percent in Arkansas. Therefore, firms exempt from the state law pursuant to ERISA employ a greater percentage of individuals in Arkansas than in Vermont. Furthermore, Arkansas has a small-employer exemption for firms with 50 or fewer employees, thus exempting an additional 18 percent of the state's population with private employer-sponsored insurance. Detailed state-by-state data tables on private employer-sponsored health insurance by firm size and self-insured status are available from the authors at Mathematica Policy Research, Inc., upon request.

In 1999, approximately 8 percent of individuals with private employer-sponsored health insurance were enrolled in health plans subject to state mental health parity laws (see Table IV.5 and Figure IV.2). Approximately 6 percent lived in a state with a mental health parity law but participated in a plan exempt from the law due to the firm's self-insured status or small size. The majority of individuals with private, employer-sponsored insurance (83 percent) live in a state without a full financial mental health parity law. Data are insufficient to estimate whether the remaining three percent—non-working individuals with employer-sponsored insurance—were subject to state parity laws.

Between 1999 and 2002, 11 states enacted parity laws, bringing the total number of states with parity laws to 24. Because 2002 data are not yet available, estimates of the sources of health insurance and the self-insurance status of firms in 2002 also are not

available. However, to provide a rough estimate of the effects of recent changes in state law, this study estimated the number of individuals who would have been covered by the new laws had the laws been in effect in 1999. If the 2002 state parity laws were applied to 1999 state populations, it was estimated that an additional 18.7 million individuals (or 15 percent of the population with employer-sponsored health insurance) would have become subject to mental health parity laws since 1999, for a total of 28.5 million (22.9 percent) in 2002.

### *3. State Parity Laws in the Individual Insurance Market*

Thirteen states require full parity in mental health benefits in individually purchased insurance plans (National Conference of State Legislatures, 2001; National Alliance for the Mentally Ill, 2002). The laws in California, Delaware, Hawaii, Massachusetts, Montana, New Jersey, and South Dakota cover serious or biologically based mental illnesses. The laws in Connecticut, Indiana, Maine, Maryland, Minnesota, Rhode Island, and Vermont cover all mental illnesses (see Table IV.6).

These state laws cover the individual market, but the degree of insurer compliance with the parity requirements is unclear. A review of several individual policies for the individual markets in those states revealed that at least some of the policies offered did not appear to be in compliance with state requirements (ehealthinsurance.com, 2002). However, the level of compliance varied by state. For instance, all of the policies offered in Connecticut appeared to be in compliance.

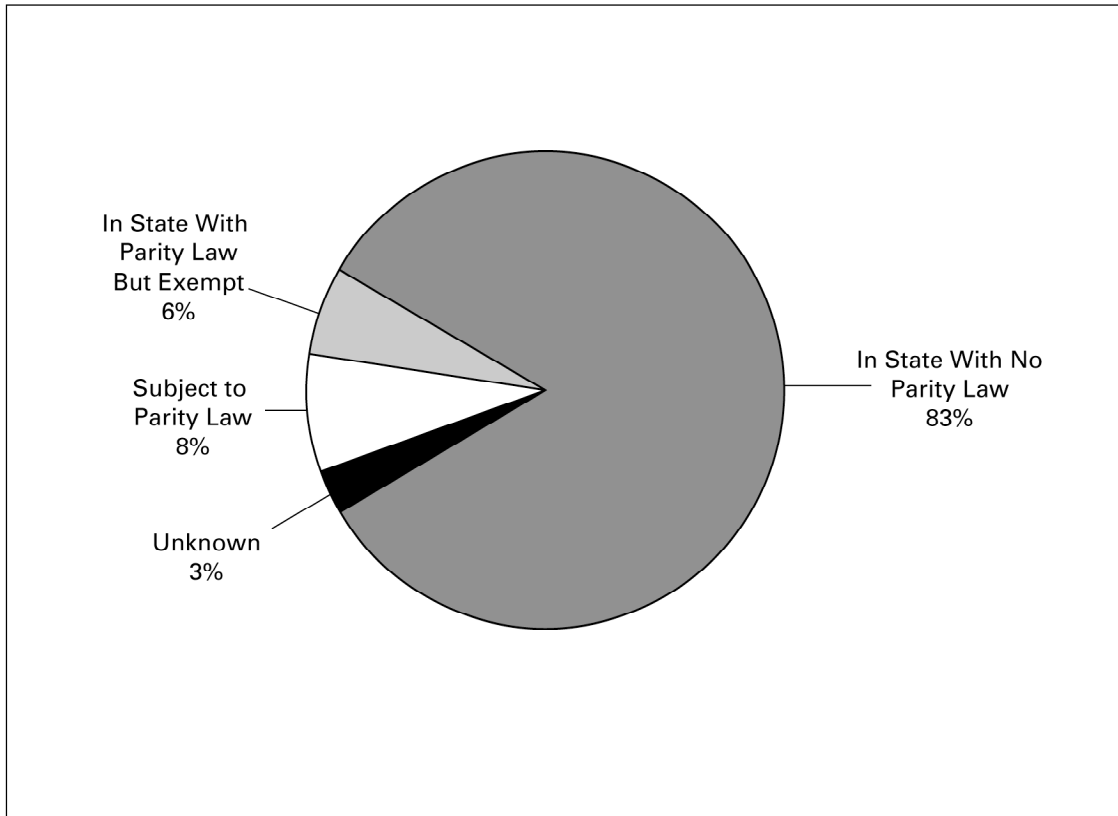
**Table IV.5. U.S. Population With Employer-Sponsored Health Insurance Covered by State Mental Health Parity Laws, 1999**

| Category of Private, Employer-Based Coverage            | Total Population With Private, Employer-Sponsored Health Insurance (millions) | Total Population With Private, Employer-Sponsored Health Insurance (percent) |
|---|---|--|
| Within State With Parity Law                            | 17.1  | 13.7   |
| Subject to Parity Law                                   | 9.8   | 7.9  |
| Exempt Due to Self-Insured Status of Firm               | 6.3   | 5.1  |
| Exempt Due to Small Employer Size                       | 0.5   | 0.4  |
| Non-Working Employer-Based                              | 0.5   | 0.4  |
| Within State Without Full Parity Law                    | 107.6   | 86.4   |
| Coverage Through Self-Insured Firm                      | 42.2  | 33.9   |
| Firm Purchases Coverage and Has Fewer Than 50 Employees | 22.4  | 18   |
| Firm Purchases Coverage and Has 50 or More Employees    | 39.8  | 31.9   |
| Non-Working Employer-Based                              | 3.2   | 2.6  |
| Total   | 124.6   | 100  |

Source: CPS estimates of the number of people covered through employer-sponsored health insurance combined with MEPS-IC calculations of the self-insured status of firms, by firm size.

Notes: Information is not available about the benefits of those classified as "non-working employer-based." These people are assumed to have coverage through a retirement plan but are ineligible for Medicare. Due to sample size limitations, the MEPS-IC is able to provide only state-specific estimates of self-insured status among firms for 37 states. For the remaining states, national numbers were used to estimate the percentage of firms self-insuring. Detailed state-by-state data tables on 1) health insurance by primary source and on 2) private employer-sponsored health insurance by firm size and self-insured status are available from the authors at Mathematica Policy Research, Inc. upon request. Table IV.4 includes notes on how the population subject to state mental health parity laws was calculated.

Figure IV.2. U.S. Population With Private, Employer-Sponsored Health Insurance Covered by State Mental Health Parity Laws, 1999



Source: CPS estimates of the number of individuals covered through employer-sponsored health insurance combined with MEPS-IC calculations of the self-insured status of firms, by firm size. Information on state parity laws from the National Conference of State Legislatures (2001) and the National Alliance for the Mentally Ill (2002).

Note: Unknown includes non-working individuals with private, employer-sponsored insurance. An unknown amount would be covered by state laws.

**Table IV.6. State Parity Laws in the Individually Insured Market in 1999**

| State                     | Year Requirement Became Effective | Diseases Covered <sup>c</sup> | Individually Insured Population in State, 1999 (millions) |
|---------------------------|-----------------------------------|-------------------------------|---|
| Connecticut <sup>a</sup>  | 1997                              | MI                            | 0.1   |
| Delaware                  | 1999                              | SMI                           | <0.1  |
| Maine                     | 1996                              | MI                            | 0.1   |
| Maryland                  | 1994                              | MI, ED                        | 0.2   |
| Minnesota                 | 1995                              | MI                            | 0.2   |
| New Jersey                | 1999                              | SMI                           | 0.3   |
| Rhode Island <sup>b</sup> | 1995                              | SMI                           | <0.1  |
| South Dakota              | 1998                              | SMI                           | 0.1   |
| Vermont                   | 1998                              | MI                            | <0.1  |

Source: National Conference of State Legislatures (2001) and National Alliance for the Mentally Ill (2002) charts on state parity laws.

<sup>a</sup> From 1997 to 1998, Connecticut's law covered serious mental illnesses. Effective 1999, the law was expanded to cover all mental illnesses.

<sup>b</sup> From 1995 to 2001, Rhode Island's law covered serious mental illnesses. Effective 2002, the law was expanded to cover all mental illnesses.

<sup>c</sup> MI: mental illnesses; SMI: serious mental illnesses or biologically based illnesses; ED: emotional disorders.

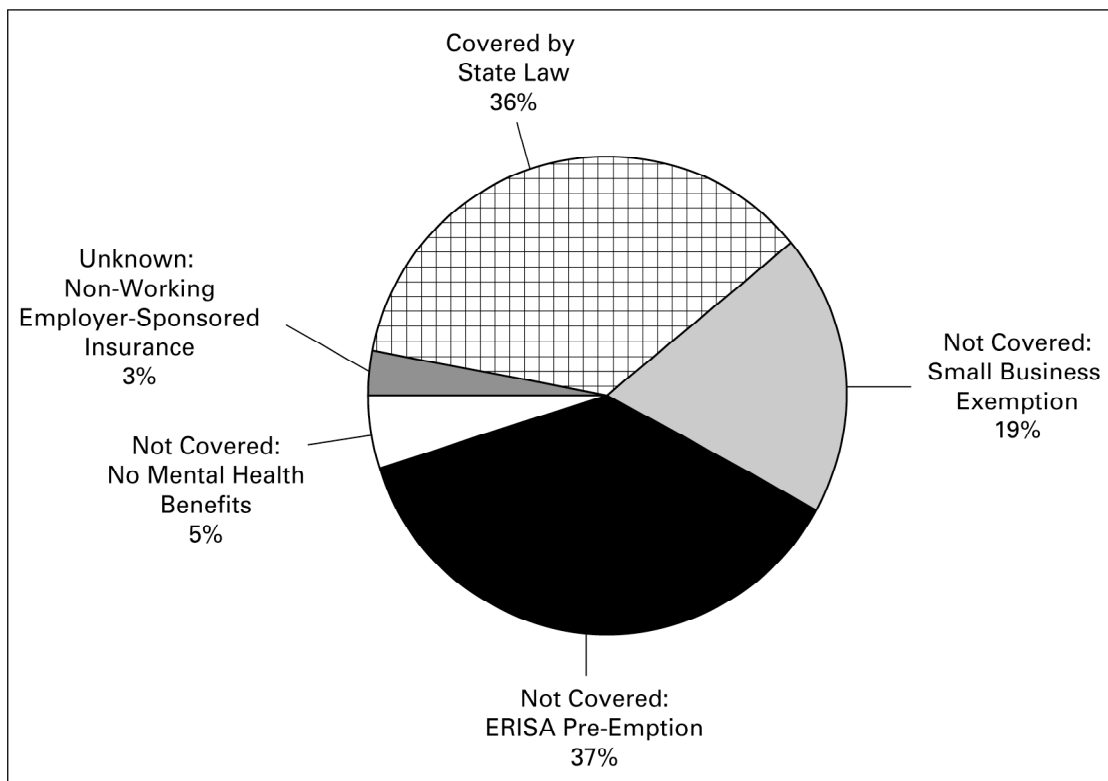
#### **4. Potential Effects of State Mental Health Parity Laws**

Even if all states had a full financial mental health parity law in effect in 1999, with a small employer exemption for firms with 50 or fewer employees, the laws ultimately would have reached only 36 percent of individuals with private, employer-sponsored health insurance (see Figure IV.3). Nineteen percent of individuals with this type of insurance coverage would have been exempt under state small business exclusions. The ERISA

preemption would have exempted another 38 percent of individuals with private, employer-sponsored insurance; an additional 5 percent would have been exempt because their employer did not offer mental health benefits. Data are insufficient to determine whether the remaining 3 percent—non-working individuals with employer-sponsored insurance—would have been subject to state laws.

If all states had implemented full, financial mental health parity laws without small business exclusions, only an additional 19 percent would have been covered, bringing the total covered by the law to 55 percent of individuals with private, employer-sponsored health insurance.

**Figure IV.3. Individuals With Private, Employer-Sponsored Insurance Who Would Have Been Subject to Full Financial Mental Health Parity Laws in 1999 if All States Had a Parity Law With a Small-Business Exclusion for Firms With 50 or Fewer Employees**



Source: CPS estimates of the number of individuals covered through employer-sponsored health insurance combined with MEPS-IC calculations of the self-insured status of firms, by firm size.

Note: Unknown includes non-working individuals with private, employer-sponsored insurance. An unknown amount would be covered by state laws.

In addition to the ERISA preemption, state parity laws also are limited in their reach since they cannot affect Federal health insurance programs. Federal and state programs account for a large share of health insurance coverage in the United States. Assuming all states had a full financial mental health parity law in 1999, with no small employer exemption, approximately 25 percent of the U.S.

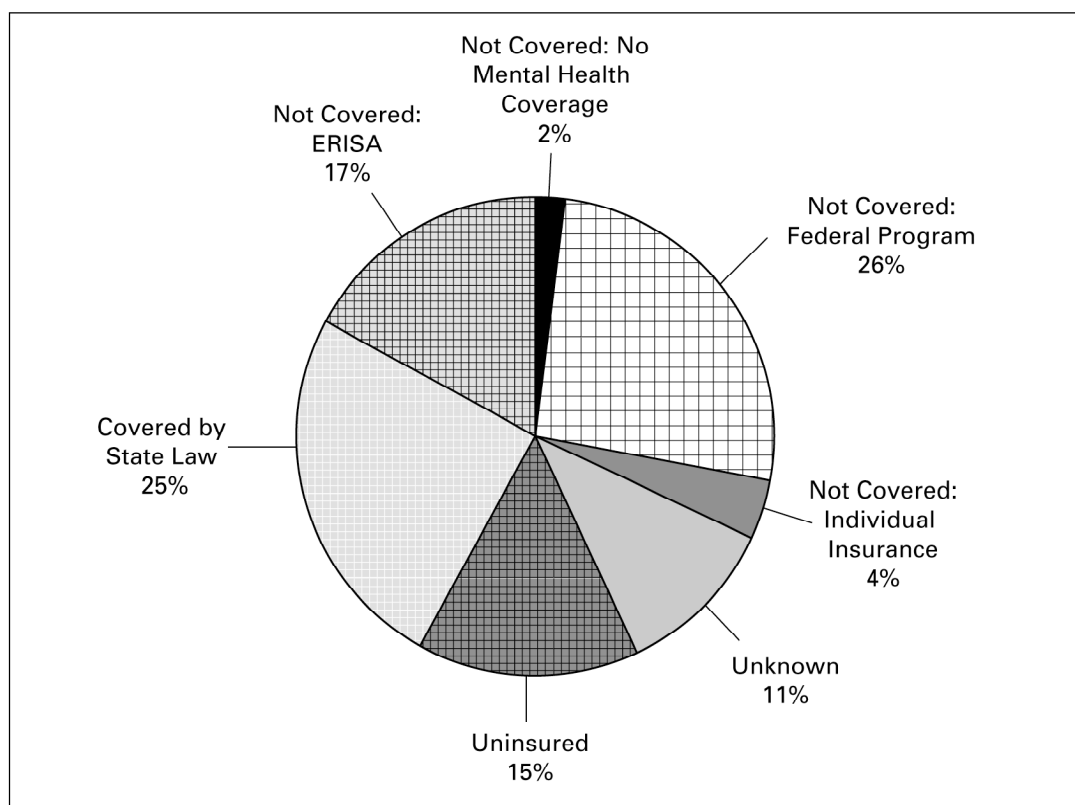
population would be subject to those laws (Figure IV.4). Approximately 17 percent of individuals would have been exempt due to the ERISA preemption. Two percent would have been exempt because their private, employer-based insurance does not cover mental health benefits. Roughly 26 percent of the U.S. population is in a Federal or state program such as Medicare, Medicaid, SCHIP,



or TRICARE, all of which would not be subject to state parity laws. Although some of these programs already have parity of coverage (e.g., Medicaid) others, including Medicare and TRICARE, do not. The individual insurance market, which insures 4 percent of the U.S. population, generally would not be covered by state parity laws unless states chose to include these insurers. Historically, they have chosen not to do so. It

is unknown whether an additional 11 percent of the population would have been subject to the laws. These individuals include participants in state/local government health plans (which states could exempt from their laws), those with insurance from a source outside the household, and non-workers with employer-sponsored coverage. Finally, state laws would not have covered the uninsured—the remaining 15 percent of the population.

**Figure IV.4. Percentage of U.S. Population Covered by State Full Financial Mental Health Parity Laws in 1999 if Each State Had a Parity Law With No Small Employer Exemption**



Source: CPS estimates of the number of individuals covered through employer-sponsored health insurance combined with MEPS-IC calculations of the self-insured status of firms, by firm size.

Note: Unknown includes non-working individuals with private, employer-sponsored insurance. An unknown amount would be covered by state laws.

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## C. Mental Health Parity Act of 1996 (MHPA)

Although MHPA did not require full financial mental health parity—it did not require equalized cost sharing or utilization limits—it is informative to look at the reach of this Federal law. The MHPA applied to group insurance plans. The law also included exemptions for small employer plans (50 or fewer employees) and businesses that could demonstrate a 1 percent increase in costs. Health plans that did not cover mental health benefits were not required to begin covering these benefits.

### 1. Coverage as a Proportion of Those With Private, Employer-Sponsored Insurance

Of approximately 124.7 million individuals in the private, employer-sponsored insurance market in 1999, 87.9 million (70 percent) had health insurance through firms with 50 or more employees that covered mental health benefits, and therefore were subject to the MHPA (Figure IV.5). Approximately 26.9 million (22 percent) were in a health plan exempt from the law's provisions because of the small business exclusion. Yet another 6.2 million (5 percent) individuals with private, employer-sponsored insurance were exempt because their coverage did not include mental health benefits at all. The final 3.7 million (3 percent) were non-working with employer-based insurance—many of whom are probably retirees not yet eligible for Medicare. It is reasonable to assume that some portion of these individuals receive their insurance through a firm of more than 50 employees, and therefore were subject to the MHPA, but the CPS does not provide firm sizes for these individuals. Thus, it is not possible to know

how many would be covered or whether these individuals were subject to the law.

### 2. Coverage as a Proportion of the Total U.S. Population

The primary population subject to the MHPA's provisions was the private, employer-sponsored group market, as the previous sections noted, but the total picture of U.S. health insurance contains many more sources of coverage. This section estimates the percentage of the total U.S. population with health insurance subject to the MHPA.

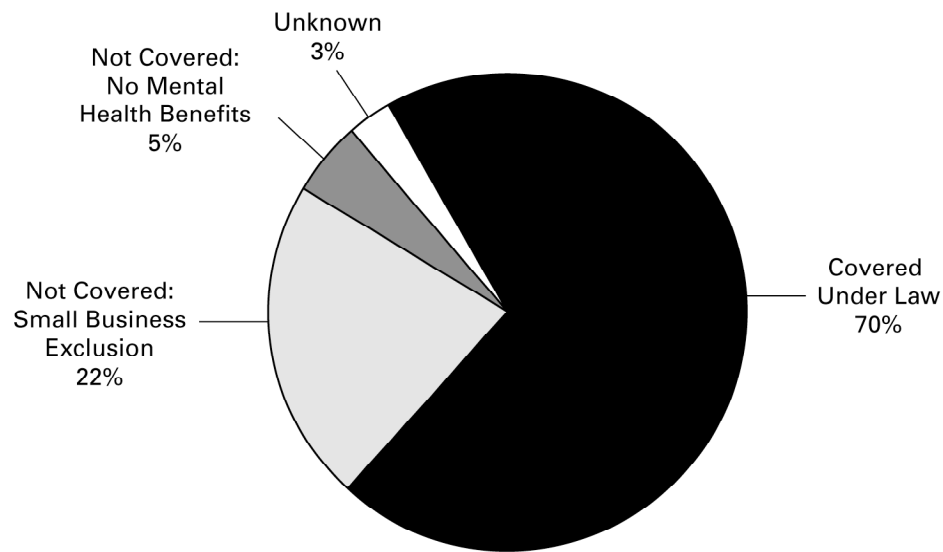
The 70 percent of individuals covered by the MHPA in the private employer-sponsored market in 1999 represents roughly 32 percent of the total U.S. population. Those with health insurance through the FEHBP (2 percent) also were covered by the MHPA. State and local government employee health plans were allowed to opt out of the law, but only a negligible number did so. Individuals in state/local government health plans with mental health benefits totaled 22.1 million (8 percent). Added together, approximately 42 percent of the U.S. population were subject to the MHPA in 1999 (Figure II.6). Another 12 percent were exempt from the law based on the small employer exemption (10 percent) or because the individual's plan did not cover mental health (2 percent). Enrollees in Federal and Federal/state programs exempted from the law, such as Medicare, Medicaid, SCHIP, and TRICARE, accounted for another 24 percent of the U.S. population.

Although some of these programs already offered full parity in mental health benefits, some did not. Individuals with individually purchased insurance, also not under the scope of MHPA, accounted for 4 percent of the U.S. population in 1999. It is unknown

whether an additional 3 percent of the U.S. population would have been subject to MHPA because these individuals either had insurance from a source outside of the house-

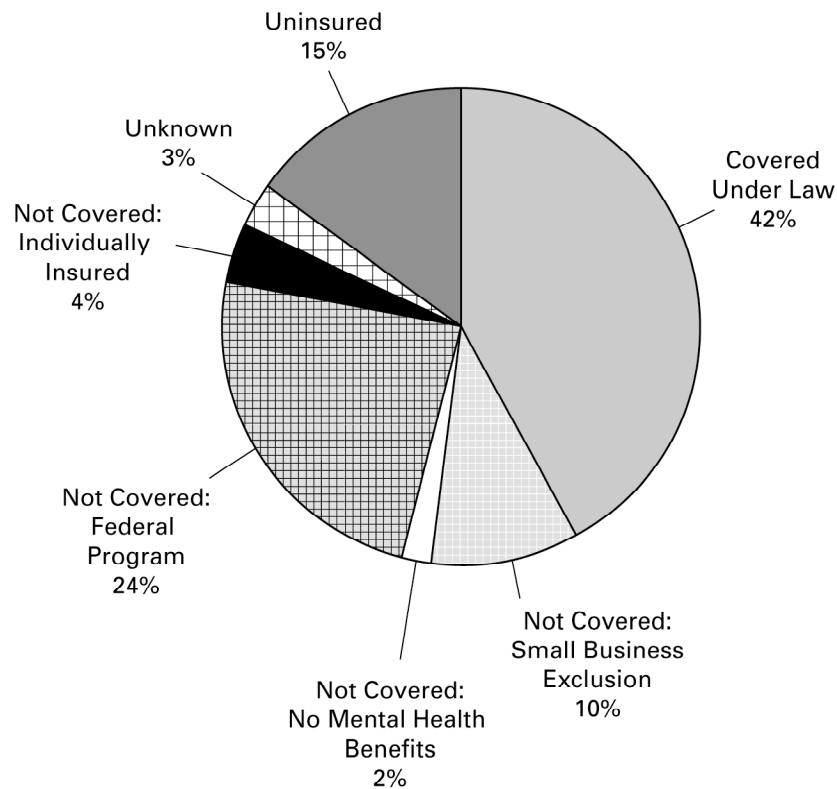
hold (2 percent) or were non-working individuals with employer-sponsored health insurance (1 percent). The remaining 15 percent of the population was uninsured.

**Figure IV.5. Private, Employer-Sponsored Health Insurance Market Subject to Mental Health Parity Act of 1996, in 1999**



Source: 2000 Current Population Survey, MEPS-IC, and Mercer Worldwide Survey. "Unknown" includes individuals with insurance from a source outside the household (2 percent) and non-working individuals with employer-sponsored insurance (1 percent).

**Figure IV.6. U.S. Population Subject to the Mental Health Parity Act of 1996, 1999**



Source: 2000 Current Population Survey, MEPS-IC, and Mercer Worldwide Survey. "Unknown" includes individuals with insurance from a source outside the household (2 percent) and non-working individuals with employer-sponsored insurance (1 percent).

## D. Summary

Nearly 38 percent of individuals with health insurance had full financial parity in mental health benefits in 1999. The private, employer-sponsored health insurance market and Medicaid were the two main insurers offering parity in benefits. Additionally, in 1999, 13 states had full mental health parity laws. However, because of the ERISA exclusion of self-insured employers and small group exemptions, state laws often do not cover large numbers of those who have health insurance through employer-sponsored plans, the main focus of such laws. In fact, just 8 percent of those with health insurance from a private, employer-sponsored plan were sub-

ject to a parity law in 1999. State mental health parity laws also generally do not cover individuals with insurance from a source outside the private, employer-sponsored market. If each state had a mental health parity law in 1999, with no small employer exemption, approximately 55 percent of the private, employer-sponsored market would have been covered—just 25 percent of the total U.S. population. Federal parity laws have the potential to cover more individuals. MPHA, with its small business exemption for firms with 50 or fewer employees, provided partial parity protection to approximately 42 percent of the U.S. population in 1999.

# V. Summary of Findings

This study estimates the proportion of the U.S. population with mental health insurance benefits, determines the generosity of available mental health insurance benefits, and estimates the proportion of the U.S. population subject to state and Federal laws mandating mental health parity.

In 1999, 76 percent of the noninstitutionalized U.S. population had mental health insurance benefits. The majority of those who did not have these benefits did not have health insurance at all.

In 1999, approximately 52 percent of individuals with health insurance had mental health benefits that met a benchmark standard of coverage of 30 inpatient days, 20 outpatient visits, and prescription drug coverage. When the uninsured are included in the total, the percentage of individuals with mental health insurance who met or exceeded the benchmark drops to approximately 44 percent of the entire U.S. population.

Approximately 20 percent of the U.S. population had mental health benefits lower than the benchmark, and at least another 2 percent had benefits that did not cover mental health services at all. Insufficient data prevented estimates for an additional 19 percent of the population, either because the individuals had mental health benefits of unknown generosity (12 percent) or because it could not be determined whether they had mental health coverage or to what extent they had any coverage (7 percent). The remaining 15 percent of the population was uninsured in 1999.

Some individuals with mental health benefits that fell short of the benchmark were covered by public insurance programs. Even though Medicare utilization limits exceeded the benchmark, the program lacked prescription drug coverage—a major component of today's treatment for mental illness. However, many individuals also had supplemental Medicare coverage to provide them with some of this protection. Also, Medicaid benefits for adults in six states did not meet the benchmark level of generosity.

Approximately 14 percent of individuals with private, employer-sponsored health insurance through a firm with 10 or more employees had mental health benefits at parity with their medical/surgical benefits. No special restrictions were imposed on mental health benefits, such as differential dollar or utilization limits, or cost-sharing requirements. Across all health insurance sources, approximately 38 percent of individuals with mental health benefits had parity in that coverage. Medicaid is a large provider of health insurance that includes mental health parity in its benefit package.

In 1999, approximately 8 percent of individuals with employer-sponsored health insurance were subject to state statutes

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requiring full mental health parity. An additional 6 percent of individuals with private, employer-sponsored health insurance lived in a state that had a mental health parity law, but were exempt as a consequence of the firm's self-insured status or small size. As of 2002, as much as 23 percent of the private, employer-sponsored market could be subject to state mental health parity laws, with an additional 11 states enacting such laws between 1999 and 2002.

If all 50 states and the District of Columbia had a full mental health parity law in 1999, with no small business exclusion, a state law would have covered approximately 55 percent of individuals with private, employer-sponsored health insurance. Approximately 37 percent would have been exempt under the Employment Retirement Income Security Act of 1974 (ERISA) preemption. Five percent would not have been covered because their insurance did not include mental health benefits. Data are insufficient to estimate whether the remaining individuals with private, employer-sponsored insurance (3 percent) would have been covered. Individuals with private, employer-sponsored insurance who would have been

covered by state laws accounted for roughly 25 percent of the entire U.S. population.

Although the Federal Mental Health Parity Act of 1999 (MHPA) did not provide full financial mental health by requiring parity in cost sharing and utilization limits, it did ensure some level of mental health parity for a larger portion of the U.S. population than was covered by state laws. In 1999, approximately 87.9 million individuals (70 percent) in the private, employer-sponsored health insurance market had health insurance through firms with 50 or more employees that covered mental health benefits, and therefore were subject to the MHPA. In addition to those in the private, employer-sponsored market, the MHPA also covered the Federal Employees Health Benefit Program (FEHBP) and nearly all state/local government health plans.

When individuals in these coverage sources are included, the MHPA reached approximately 42 percent of the U.S. population in 1999. Even with its small business exclusion, the Federal law reached nearly twice the number of individuals who would have been covered had every state enacted a mental health parity law without a small business exclusion.







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# Appendix A: Sources of Health and Mental Health Insurance

This appendix reviews the major sources of mental health insurance in the United States, as well as recent research on each source. The review begins with private, employer-sponsored insurance and extends to public sources of mental health insurance. Sources of insurance are presented in order of the number of covered individuals.

## A. Employer-Sponsored Plans

Nearly half the U.S. population is covered by employer-sponsored health insurance. The General Accounting Office (GAO) (2000a) found that a large majority of employers provide mental health insurance, but they impose more restrictive limits on that coverage than on the medical and surgical insurance they offer. Since the Mental Health Parity Act (MHPA) of 1996 prohibited employers from imposing different dollar limits on mental health coverage than on medical and surgical coverage, employers increasingly have substituted utilization limits for dollar limits.

Sturmand Pacula (2000) found that in 1999, 80 percent of individuals with mental health insurance had inpatient day or outpatient visit limits. More than 50 percent of such individuals were limited to 20 or fewer outpatient visits; approximately 60 percent were limited to 30 or fewer inpatient days.

Jensen et al. (1998) reviewed how mental health benefits provided through employer-sponsored health plans changed from 1991 to 1995. They found that, although a larger number of employer health plans included mental health benefits, the benefits became more restrictive over the study period. In addition, plans increasingly imposed separate limits for outpatient mental health visits and inpatient days. Furthermore, in 1995, individuals enrolled in health maintenance organizations (HMOs) were more likely to face stricter day or visit limits than those not enrolled in HMOs. For example, 88 percent of the HMOs placed a limit on visits, but only 36 percent of non-HMOs imposed such a limit. Seventy-six percent of the study's non-HMOs imposed a dollar limit on outpatient care, while 16 percent of the study's HMOs imposed such a limit.

In another study, Buck and Umland (1997) found that from 1989 to 1995,

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employers substituted utilization limits for dollar limits. For example, in 1985, 62 percent of employers limited the maximum amount per lifetime on outpatient visits, and 33 percent limited the number of visits per year. In 1995, 37 percent of employers limited the maximum amount per lifetime on outpatient visits; 48 percent limited the number of visits per year. The most common outpatient benefit limit imposed by HMOs was 20 visits, which, as Buck and Umland note, is the amount specified by the Health Maintenance Organization Act of 1973 for federally qualified HMOs. From 1986 to 1994, HMOs increasingly were likely to require co-payments as opposed to co-insurance for mental health care, thereby controlling costs.

Following implementation of the MHPA, the U.S. Government Accounting Office (2000a) found that employers were imposing mental health service limits that were more restrictive than limits for medical and surgical benefits. In a survey of employers subject to the MHPA, GAO found that 87 percent of respondents who complied with the MHPA's provisions still were subject to more stringent limits on mental health coverage than on medical and surgical benefits. Furthermore, approximately two-thirds of employers who changed their dollar limits to comply with the law made their mental health benefits more restrictive by lowering the number of visits or days, or by raising co-insurance rates. Most of these newly compliant employers covered fewer office visits for mental health than they had in the past.

## **B. Medicare**

Enacted in 1965, Medicare is the largest publicly sponsored health insurance program in

the United States, covering an estimated 36.1 million individuals in 1999. The majority of Medicare beneficiaries—87 percent in 1999 (Centers for Medicare and Medicaid Services, 2000a)—are elderly, aged 65 years and older.

The elderly qualify for Medicare based either on their own or their spouse's contributions to the program for at least 40 quarters, through payroll taxes. Those who are otherwise eligible but have not contributed for the full 40 quarters may buy into the program by paying additional premiums.

Approximately 13 percent of the Medicare population is under age 65 and qualifies by being either totally and permanently disabled or diagnosed with end-stage renal disease (ESRD). Approximately 10 percent of all Medicare beneficiaries—including 41 percent of Medicare beneficiaries under age 65—self-report a mental disorder (Sharma, 2001).

Medicare's benefit package is divided into Parts A and B. Part A provides hospital insurance; Part B provides coverage for physician services and outpatient expenses. Stays in psychiatric hospitals are subject to the same cost-sharing structure applicable to stays in general hospitals, including an \$812 Part A deductible<sup>1</sup> per benefit period.<sup>2</sup> In addition to the deductible, beneficiaries must pay \$203 per day for days 61 through 90 of a hospital stay and \$406 for days 91 through 150.<sup>3</sup> Beneficiaries must pay all costs for days spent in the hospital beyond 150 per benefit peri-

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<sup>1</sup> In 1999, the Part A deductible was \$768 per benefit period.

<sup>2</sup> Medicare defines a benefit period as a spell of illness that ends after a beneficiary does not receive care in a hospital or skilled nursing facility for 60 days.

<sup>3</sup> In 1999, the co-payments for hospital stays were \$192 for days 61 through 90 and \$384 for days 91 through 150.

od. Sixty lifetime inpatient hospital reserve days with a co-insurance of \$406 per day<sup>4</sup> also are available (Centers for Medicare and Medicaid Services, 2001a). Medicare limits inpatient stays in psychiatric hospitals to 190 lifetime days. Mental health care in a general hospital, such as in a psychiatric unit, is not subject to the 190-day lifetime limit.

Part B has an annual \$100 deductible, which includes both mental and physical health care. For most physician services, the beneficiary co-insurance is 20 percent. However, Medicare beneficiaries pay 50 percent for visits to psychologists and 20 percent for visits to psychiatrists and hospital outpatient clinics (Centers for Medicare and Medicaid Services, 2001b; Hennessy, 2000). No utilization limits are placed on the number of outpatient mental health visits for Medicare beneficiaries. Medicare does not cover the cost of prescription drugs, which have become increasingly important in the treatment of mental illness over the last decade.

Due to limitations in Medicare's benefit package, 88 percent of Medicare beneficiaries in 1999 had some form of supplemental insurance coverage (Laschober, 2002). Below are descriptions of the major sources of supplemental Medicare insurance.

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<sup>4</sup> The co-payment for the lifetime reserve days in 1999 was \$384 per day.

<sup>5</sup> The program has declined substantially since 1999 in terms of enrollment and the comprehensiveness and affordability of benefits; however, many M+C enrollees can still obtain mental health coverage through their HMO that is more affordable and comprehensive than that in fee-for-service Medicare. In 2002, M+C enrollment is just over 5 million, or approximately 14 percent of the total Medicare population (Centers for Medicare and Medicaid Services, 2002a).

### ***1. Medicare+Choice (M+C)***

In 1999, more than 6.3 million Medicare beneficiaries, or roughly 16 percent, were enrolled in Medicare's managed care program, Medicare+Choice (Health Care Financing Administration, 1999a).<sup>5</sup> Medicare+Choice plans must cover all Medicare benefits that are part of the traditional Medicare benefit package.

Cost sharing under Medicare HMOs generally is less than traditional fee-for-service Medicare. Some plans, however, recently have instituted cost sharing for certain services, including inpatient mental health stays, which can be higher than traditional Medicare (Achman and Gold, forthcoming). This cost sharing is allowed because M+C plans are required to have an actuarial value only that is equal to or more than the entire Medicare benefit package and thus may go below the value of individual benefits.

Medicare+Choice plans are allowed to offer supplemental benefits not covered in the traditional Medicare benefit package. These benefits are financed either through the savings the plan can generate by providing traditional Medicare services or by charging enrollees additional monthly premiums. In 1999, approximately 84 percent of Medicare+Choice enrollees had prescription drug coverage (Cassidy and Gold, 2000). Twenty-two percent of enrollees with drug coverage had an unlimited prescription drug benefit; the remaining 78 percent had some annual cap on benefits.<sup>6</sup>

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<sup>6</sup> Because of the tighter budgets of Medicare+Choice plans since 1999, only 71 percent of M+C enrollees have any prescription drug coverage in 2002 (Achman and Gold, 2002). Many plans that continue to cover prescription drugs limit that coverage by excluding brand-name drugs or imposing a particularly low annual dollar limit on brand-name drugs, sometimes under \$500.

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## 2. Medigap Insurance

In 1999, 24 percent of Medicare beneficiaries had supplemental coverage under a Medigap plan (Laschober et al., 2002). Medigap plans fill much of the cost sharing required under Medicare. Two-thirds of all Medigap plans take the form of one of 10 standardized policies (Plan A through Plan J) by the Centers for Medicare and Medicaid Services [CMS]; the remaining plans were purchased before 1990, with little currently known about the specific benefits they cover.

The standardized policies cover the co-insurance for both Part A and Part B, the Part A deductible, and 365 additional hospital days during a beneficiary's lifetime. The additional 365 days are for general hospitals and do not extend the 190-day limit for inpatient care at psychiatric hospitals.

Three Medigap plans (H, I, and J) cover prescription drugs, though their coverage is relatively limited compared with most private insurance plans.<sup>7</sup> Only about 27 percent of Medicare beneficiaries with Medigap supplemental insurance had some drug coverage in 1999 (Laschober et al., 2002).

Medigap plans can provide financial protection for the elderly, but they are less likely to help the disabled population under age 65, for which a much higher incidence of mental disorders is reported. For the most part, insurers are not required to sell Medigap

policies to Medicare beneficiaries under age 65. Only 19 states require a special open enrollment period for at least one of the standardized Medigap policies for beneficiaries under age 65.<sup>8</sup>

## 3. Employer-Sponsored Retiree Coverage

Approximately 33 percent of Medicare beneficiaries in 1999 had supplemental health insurance through a current or former employer (Laschober et al., 2002). Retiree health insurance for the population over 65 years of age generally wraps around the Medicare benefit package, reducing individual out-of-pocket costs for co-insurance and deductibles. A typical large employer's retiree health plan for Medicare eligibles includes a \$300 deductible, 80 percent employer co-insurance, and an out-of-pocket limit of \$1,750 (McArdle et al., 1999).

No information currently exists on the provisions in retiree health coverage specific to mental health services. In 1999, approximately 83 percent of Medicare beneficiaries with employer-sponsored supplemental insurance had some drug coverage (Laschober et al., 2002).

The share of all employers offering health benefits to Medicare-eligible retirees has been shrinking over the past decade and is expected to continue to decline in the near future (Kaiser Family Foundation et al., 2002). In addition, more employers are expected to shift a greater share of costs onto retirees by increasing premium contributions and imposing greater cost-sharing requirements (Kaiser Family Foundation et al., 2002).

## 4. Dual Eligibility With Medicaid

Low-income Medicare beneficiaries can qualify for supplemental Medicare coverage through state Medicaid programs. In 1999,

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<sup>7</sup> Plans H and I have an annual deductible of \$250 and cover 50 percent of drug costs up to \$1,250 per year. Plan J also has an annual deductible of \$250 but pays 50 percent of drug costs up to \$3,000 per year (Health Care Financing Administration, 2001b).

<sup>8</sup> California, Connecticut, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, Texas, and Wisconsin (Health Care Financing Administration, 2001b).



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approximately 11 percent of Medicare beneficiaries had supplemental coverage from Medicaid. Federal law requires that state Medicaid programs cover Medicare Part B premiums and Medicare cost-sharing expenses for Medicare beneficiaries with incomes less than 100 percent of the Federal poverty level and resources less than twice the Social Security Income program limit (Ellwood and Quinn, 2001). In addition, those who meet state Medicaid income and asset standards can qualify for full Medicaid benefits. In fact, the vast majority of those who are dual eligibles in all states also qualify for full Medicaid benefits in addition to their Medicare benefit package (Ellwood and Quinn, 2001).

Additional benefits depend on the state, but may include case management and adult day care services, which can be valuable to individuals with a mental disorder. All state Medicaid programs also cover outpatient prescription drugs. In 1999, 89 percent of dual eligibles had prescription drug coverage.<sup>9</sup>

Medicaid pays the Medicare deductibles and co-insurance for dually eligible individuals. However, only about a third of state Medicaid programs cover the Medicare co-insurance requirements in full (Ellwood and Quinn, 2001). The remaining states use the Medicaid rate schedule to determine the level of payments for service providers, which can be less than the Medicare amount. If providers are unwilling or unable to accept the Medicaid payment rates, low reimbursements for Medicaid enrollees could pose a potential access barrier to individuals receiving services.

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<sup>9</sup> The remaining individuals, presumably, do not qualify for full Medicaid benefits.

## C. Medicaid

Medicaid, a means-tested entitlement program for low-income individuals, is financed jointly by the Federal government and the states. Each state generally sets its own eligibility requirements, usually based on a combination of income, assets, and categorical aid status. The most common categories of enrollees are low-income children, pregnant women, the elderly, disabled persons, and parents meeting specific income thresholds.

Since Medicaid focuses on enrolling individuals in poverty or with disabilities, the program is particularly important for adults with serious mental illnesses and children with severe emotional disorders. Medicaid accounts for nearly 20 percent of all spending on mental health services in the United States (Mark et al., 2000).

In June 1999, approximately 56 percent of the national Medicaid population were enrolled in some managed care arrangement (Health Care Financing Administration, 1999b). Managed care arrangements ranged from HMOs with prepaid capitated contracts to loosely structured networks of providers that use gatekeeping to control utilization. In states with Medicaid managed care, mental health services can be carved out of the managed care contract so that they remain in the fee-for-service setting; are included under the managed care contract; or are provided under a behavioral health managed care plan separate from their physical health managed care plan.

Medicaid benefit packages cover a large array of services. The Federal government mandates that all states must cover a core benefit package, including inpatient and outpatient hospital services, physician services, laboratory and x-ray services, nursing home and home health care services, and early and

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periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. States also may receive the Federal match by covering optional services, such as mental health care, prescription drugs, and speech and occupational therapy.

Under EPSDT, children under 21 years of age are supposed to receive a periodic comprehensive health and developmental assessment that includes both physical and mental health assessments (Centers for Medicare and Medicaid Services, 2002b). Should a mental or physical problem be identified, the state is required to provide all medically necessary care to “correct and ameliorate” that problem, “even if the service is not available under the State’s Medicaid plan to the rest of the Medicaid population” (Centers for Medicare and Medicaid Services, 2002b). Even though this provision technically entitles Medicaid-enrolled children to all medically necessary care for a mental health condition, EPSDT requirements are not well understood, and there is much variation in the level of state adherence to such requirements. For this reason, the U.S. General Accounting Office (2001) has reported that many eligible children are not receiving EPSDT services.

Although Medicaid is supposed to provide for all medically necessary mental health care for children, care for adults can be more restrictive. The most commonly noted restriction on adult mental health services under Medicaid is the Federal Institution of Mental Diseases (IMD) exclusion for adults 22 to 64 years of age. An IMD is defined by Federal law as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services” (Health Care

Financing Administration, 1992). The definition includes all state, county, and private psychiatric hospitals. Under the IMD exclusion, an adult treated in an IMD is not eligible for the Federal Medicaid match.

Consequently, states generally exclude from their benefit package inpatient psychiatric care for adults admitted to psychiatric hospitals. Short-term psychiatric care at general hospitals with a psychiatric unit can, however, be covered. States may elect to cover IMD services for individuals aged 65 years and older as an optional service.

Eight states—Arizona, Delaware, Maryland, Massachusetts, Oregon, Rhode Island, Tennessee, and Vermont—have received partial waivers from the Medicaid IMD exclusion for persons 22 to 64 years of age through 1115(b) Medicaid managed care waivers (Kuo and Draper, 2002). Under the waivers, the eight states can receive Federal Medicaid money for 22- to 64-year-old patients, although Federal reimbursement usually is limited to 30 days per episode and 60 days per year, and may be restricted to certain hospitals.<sup>10</sup>

#### **D. State Children’s Health Insurance Program (SCHIP)**

In 1997, Congress enacted the State Children’s Health Insurance Program (SCHIP) to expand health insurance coverage for children. As originally conceived, SCHIP provided states with Federal matching funds to insure uninsured, low-income children not eligible for Medicaid by expanding their Medicaid program (called M-SCHIP), design-

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<sup>10</sup>Rhode Island’s waiver has no limits on days and applies only to one private psychiatric hospital. Maryland’s waiver applies only to private psychiatric hospitals. Oregon’s waiver applies to only one private facility (Kuo and Draper 2002).

ing a separate child health program (S-SCHIP), or combining the two approaches. As with Medicaid, income eligibility levels for SCHIP vary according to state. In Federal fiscal year 1999, nearly two million children nationwide received health insurance through the SCHIP program at some point during that year (Centers for Medicare and Medicaid Services, 2000b).<sup>11</sup>

States choosing to expand their Medicaid programs to cover all or a portion of their SCHIP populations through an M-SCHIP program must provide the full Medicaid benefit package (Center for Mental Health Services, 2000). For states that choose to implement a separate child health program (S-SCHIP), their benefit package must be comparable to one of four benchmark plans: the Federal Employees Health Benefits Program (FEHBP) standard option plan; the state's employee health benefit plan; the HMO with the largest commercially enrolled population in the state; or another package approved by the Federal government.

Specific to mental health benefits, the S-SCHIP program must include coverage that is at least 75 percent of the actuarial value of those of the selected benchmark plan (Center for Mental Health Services, 2000). Since many private insurance plans include limits on outpatient visits and/or inpatient days, the benefit packages under S-SCHIP can be much

less generous than the benefit under Medicaid (National Conference of State Legislatures, 2001). In 2000, 10 of the 33 states with S-SCHIP programs had no limits on either outpatient or inpatient mental health benefits (see Appendix D).

## **E. Federal Employees Health Benefits Program (FEHBP)**

FEHBP is the health insurance program for employees of the Federal government. Before 2001, health plans participating in FEHBP were required to offer a minimum mental health benefit of 50 percent of the cost of 30 inpatient mental health days and 20 outpatient mental health visits (Office of Personnel Management, 2001). In addition, per the MHPA, health plans were not allowed to impose separate annual or lifetime dollar limits on mental health care.

Beginning in 2001, the FEHBP required full mental health parity for all participating health plans. Under FEHBP's current full parity requirements, health plan coverage of mental illness must have parity in utilization limits and cost sharing as applicable to medical, surgical, and hospital providers. The parity requirements cover all mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (Office of Personnel Management, 2000).

The Office of Personnel Management, the agency that oversees FEHBP, encourages health plans to manage mental health care utilization, including the use of managed behavioral health care organizations. Other permitted utilization management tools include prior authorization, directing an enrollee to a specific provider, and requiring that a treatment plan authorized by the health plan be followed.

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<sup>11</sup>Since 1999, enrollment in SCHIP has increased significantly as states have expanded their programs and enhanced outreach efforts. In FY 2001, 4.6 million children were enrolled in SCHIP nationwide at some point during the year (Centers for Medicare and Medicaid Services, 2002c). In addition, some states received waivers to begin enrolling parents in their S-SCHIP programs. In FY 2001, more than 236,000 adults were enrolled in state SCHIP programs (Centers for Medicare and Medicaid Services, 2002c).

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## **F. TRICARE**

TRICARE is the health system operated by the U.S. Department of Defense for active-duty members of the armed forces and their dependents, military retirees and their dependents, and surviving spouses of deceased active-duty or retired military service members. The TRICARE program includes three options: an HMO option (TRICARE Prime), a preferred provider organization (PPO) option (TRICARE Extra), and a fee-for-service option (TRICARE Standard, formerly CHAMPUS).

The three programs differ by provider structure, but they all provide the same mental health benefits. Authorization is required for outpatient psychotherapy that involves more than two sessions per week and/or eight sessions per year. Inpatient hospitalization for adults is covered for up to 30 days per year, inpatient hospitalization for children is covered for up to 45 days, and treatment in a residential treatment facility is covered for up to 150 days (TRICARE, 2000). With the approval of the TRICARE contractor, TRICARE enrollees can receive waivers for treatment that extends beyond these limits. Depending on both the TRICARE enrollee's eligibility status (e.g., whether an individual is a military retiree or active-duty family member) and the specific TRICARE plan (TRICARE Prime, Extra, or Standard), cost sharing for mental health services also can be higher than for other health care core services.

## **G. Veterans Affairs**

The Department of Veterans Affairs (VA) provides care to eligible veterans, generally at VA hospitals. Enrollment and eligibility for care are based on seven priority groups in accordance with the veteran's health status and financial circumstances. Veterans with

service-connected disabilities of 50 percent or more receive the highest priority; veterans without a disability, whose annual income and net worth are above the established limits, receive the lowest priority.

The VA provides unlimited inpatient and outpatient mental health and prescription drugs (Department of Veterans Affairs, 2002). Cost sharing for care received through the VA is a product of an individual's priority level (Department of Veterans Affairs, 2002). Care related to a disability resulting from military service is available without charge to all veterans. For care unrelated to a service-connected disability, inpatient mental health care involves the same cost-sharing requirements as other inpatient hospital care. Outpatient mental health visits are billed at the specialty care rate for all medical specialties. Since the VA does not limit mental health care separately from other health benefits and the cost-sharing requirements are the same, the VA meets the definition of mental health parity.

## **H. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)**

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is the federally administered health benefits program for dependents and survivors of veterans who have a total and permanent disability or who died from a disability incurred or aggravated during active-duty military service. CHAMPVA is a fee-for-service plan with a deductible (\$50 per person or \$100 per family) and 25 percent co-insurance. Unlike those receiving care through the VA, CHAMPVA enrollees may receive care from any provider. If an enrollee has other health insurance, CHAMPVA acts as a second payor

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covering the lesser of 75 percent of the Medicare-allowed amount or the balance of the charges (Department of Veterans Affairs, 2001a).

CHAMPVA requires prior authorization for inpatient mental health care and generally limits services to 30 days of care per fiscal year for adults and 45 days per year for children 18 years and younger. Beneficiaries may be able to obtain a waiver of the day limits if they meet certain conditions. Psychotherapy during an inpatient hospital stay is limited to five sessions per week. Under its outpatient mental health benefit, prior authorization is required for more than 23 psychotherapy sessions per fiscal year. Prior authorization also is required from the CHAMPVA mental health contractor for visits beyond these limits. CHAMPVA covers partial hospitalization up to 60 days per fiscal year (Department of Veterans Affairs, 2001b).

## **I. Indian Health Service (IHS)**

Through health facilities located on or near Indian reservations, the Indian Health Service (IHS) provides health care to American Indians and Alaska Natives who are members of federally recognized tribes. American Indians and Alaska Natives may receive services at IHS facilities if they live in geographic areas where facilities are located. All facilities provide preventive and health promotion services; medical care and treatment services are provided, as available, at IHS facilities or on a contractual basis from the private sector through Contract Health Services (CHS). IHS is considered a payor of last resort. In other words, any care provided to IHS-eligible individuals who also are eligible for Medicare, Medicaid, or any other third-party reimbursement at an IHS facility must be reimbursed first by the other payor.

The IHS Mental Health and Social Services program, a community-oriented clinical and preventive services program, offers mental health services (Indian Health Service, 2002), with most individual mental health services provided on an outpatient basis. IHS facilities in tribal locations offer virtually no partial hospitalization, transitional living, or child residential services. Inpatient mental health services are provided under contract at local general, private psychiatric, and state psychiatric hospitals.

## **J. Individually Purchased Insurance**

Those without access to health insurance in the group market may elect to purchase insurance in the individual market. A wide variety of individuals, including early retirees without retiree benefits, the self-employed, those whose employers do not offer health insurance, and those who have exhausted their continued group coverage allowable through the Consolidated Omnibus Budget Reconciliation Act (COBRA), hold individual health insurance policies. Persons 60 to 64 years of age are nearly three times as likely to be covered by individual health insurance as those 20 to 29 years of age (U.S. Government Accounting Office, 1996).

In contrast to the group health insurance market, most states allow companies selling individual health insurance policies to accept or deny an applicant based on the individual's health status, including his/her mental health status. Applicants often are required to provide a medical history and may be required to undergo a medical examination (Gabel, 2002). Only 11 states require all insurers in the individual market to accept all applicants regardless of health status (U.S. Government Accounting Office, 2002).<sup>12</sup>

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For persons with a history of mental illness, the purchase of comprehensive mental health coverage in the individual market can be difficult and/or expensive. According to most insurers, a history or the current treatment of a mental illness qualifies an individual as high-risk (U.S. Government Accounting Office, 2002). Even if an individual with mental illness is offered a policy, the policy likely will include higher premiums and/or benefit restrictions beyond those offered in a standard individual policy.

Although data limitations preclude this report from including an estimate of the extent or generosity of mental health benefits in the individual market, Gabel et al. (2002)

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<sup>12</sup>Eight of the 11 states require all carriers to guarantee issue throughout the year (Idaho, Maine, Massachusetts, New Hampshire, New Jersey, New York, Ohio, and Vermont), while the other three states impose the requirement only on certain carriers or during special open-enrollment periods (Maryland, Michigan, and West Virginia). Carriers in five additional states (Hawaii, North Carolina, Pennsylvania, Rhode Island, and Virginia) and the District of Columbia voluntarily guarantee access to coverage regardless of health status. As of July 2002, New Hampshire allows insurers to deny coverage based on health status (U.S. General Accounting Office, 2002).

reviewed 103 individual insurance products in 10 states and found that 63 percent included inpatient mental health coverage, and 48 percent included outpatient mental health coverage. The rates and extent of mental health coverage varied according to whether the product was an indemnity, HMO, or preferred provider/point-of-service plan. For plans that include mental health benefits, restrictions and limitations are common. Individuals obtaining mental health services under such plans generally face higher co-payments and co-insurance (sometimes up to 50 percent) (Chollet and Kirk, 1998). Separate annual and/or lifetime dollar limits for mental health services below those of the plan's overall limit also are common since the MHPA never applied to individually purchased policies. Pollitz et al. (2001) found that lifetime limits on mental health coverage usually average \$10,000, while overall plan limits can range from \$1 million to \$6 million. In addition to, or in place of lifetime caps on mental health benefits, individual plans may impose annual limits; annual benefit limits of \$3,500 or less are common (Pollitz et al., 2001).

# VIII. Appendix B: Methods

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**T**his appendix summarizes the methods used by the study team to estimate the proportion of the U.S. population with mental health insurance in 1999. Estimates of the number of individuals with health insurance by primary source of health coverage are derived from the March 2000 Current Population Survey (CPS).

Estimates of the proportion of those with health insurance who have mental health benefits are based on the 1999 Medical Expenditure Panel Survey—Insurance Component (MEPS-IC). Estimates of the generosity of benefits are based on the 1999 Mercer Worldwide Survey of Employer-Sponsored Health Plans. Section A describes each data source. Section B presents the methods used to estimate the major results of this report.

## **A. Data Sources**

### **1. Current Population Survey**

The CPS is a monthly survey conducted by the Bureau of the Census, and is the official source of government statistics on unemployment and employment. Each month, demographic and employment data are obtained from approximately 47,000 noninstitutionalized households selected to represent the U.S. population. In March of each year, the CPS collects additional data on work experience, income, and employer-sponsored benefits, such as health insurance. The interviewer lists types of health insurance (employer-based, privately purchased, Medicare, Medicaid, military health care, or other), and the respondent indicates whether he or she

was ever covered by that type of insurance in the previous year (for example, 1999 for the March 2000 survey). The respondent also lists the source of insurance coverage for other individuals in the household.

Because of the CPS's large sample size and the focus on timeliness in releasing the data, researchers who are examining current sources of health insurance coverage for the U.S. population frequently use the March CPS. The CPS variables used for this study are:

- Source of health insurance coverage
- Demographic characteristics: age, income level, ethnicity, location of residence
- Characteristics of employer: size of firm, type of industry, type of occupation (private sector, state, local, or Federal government)

### **2. Medical Expenditure Panel Survey—Insurance Component (MEPS-IC)**

The 1999 MEPS-IC was a survey of a probability sample of slightly more than 20,000 U.S. employers. The Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS), both part of the U.S. Department of

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Health and Human Services (DHHS), cosponsored the survey. The MEPS-IC collected data on the number and types of health insurance plans offered, the benefits associated with these plans, premiums, contributions by employers, and employer characteristics. The sample of private employers was selected from the Bureau of the Census's Standard Statistical Establishment List. The sample included Federal, state, and local governments. Local government employers were selected from the Census of Governments.

The survey response rate was 66.1 percent, and a total of 20,003 private employers from the list sample completed the questionnaire in 1996.<sup>13</sup> In that year, 2,224 state and local government employers responded to the survey (84.6 percent response rate).<sup>14</sup> Because of the sample size limitation, statistically valid data are available by state for only the 37 most populous states. MEPS-IC variables used in this study are:

- Establishment size
- Firm size
- Whether the firm offered health insurance
- Whether the firm offered coverage for outpatient mental health services
- Whether the firm offered coverage for inpatient mental health services
- Whether the firm was self-insured
- Whether retirees were eligible to receive hospital/physician coverage

- How many employees were eligible for health insurance at the establishment surveyed
- How many employees were enrolled in health insurance at the establishment surveyed
- Number of employees with single or family coverage

### *3. Mercer Worldwide National Survey of Employer-Sponsored Health Plans*

The accounting and benefits consulting firm Mercer Worldwide conducts an annual survey of a nationally representative sample of private employers with 10 or more employees who offer health insurance. In 1999, 2,737 employers responded to the survey, including state and local governments. Private employers were selected into a probability sample from the list of firms<sup>15</sup> with 10 or more employees, which is maintained by Dun & Bradstreet. The response rate was 52 percent.

Information was collected on the types of health services covered, the generosity of benefits, and the cost of benefits by plan type—health maintenance organization (HMO), preferred provider organization (PPO), and fee-for-service (FFS) plan. The variables used in this study include:

- Whether the plan covered inpatient and outpatient mental health care
- Annual and lifetime limits on outpatient mental health visits
- Annual and lifetime limits on inpatient mental health days
- Copayment, co-insurance, and deductible for mental health care
- Annual and lifetime dollar limits

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<sup>13</sup>AHRQ has not yet published the response rate of the 1999 MEPS-IC survey.

<sup>14</sup>See Construction of Weights for the 1996 Medical Expenditure Panel Survey Insurance Component List Sample, Methodology Report 8, U.S. Department of Health and Human Services, Agency for Health Care Policy and Research, November 1999.

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<sup>15</sup>The business unit listed is the one applying for a loan or a line of credit. This unit may differ from the entire corporation.



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## B. Methods

The data sources for the study included the March 2000 Current Population Survey (CPS), the 1999 Medical Expenditure Survey-Insurance Component (MEPS-IC), and the Mercer Worldwide National Survey of Employer-Sponsored Health Plans. Each survey uses a nationally representative probability sample, with 1999 serving as the reference period for each survey. The CPS contains data from a sample of approximately 47,000 households on their health insurance coverage. The MEPS-IC contains data from a sample of approximately 20,000 public and private employers about the health insurance benefits they provide to their employees. The National Survey of Employer-Sponsored Health Plans is sponsored by Mercer Worldwide and contains data from a sample of approximately 2,700 private employers regarding the detailed provisions of their health insurance plans.

The unit of analysis in this study is the individual (the policyholder, as well as his or her covered family members). Given that the CPS is the only one of the three databases used for this study that contains data on individuals, it served as the host database. The other two databases were used to impute values to the CPS that are not provided by that database. Imputed information includes greater detail on firm size and health plan provisions than what is available in the CPS.

Estimating the number of individuals who have mental health insurance benefits is a three-step process. In the first step, the number of individuals covered by each source of health (as opposed to mental health) insurance is estimated. In the second step, the proportion of individuals with each type of health insurance who are covered by mental health insurance is estimated. In the third

step, the estimates from the first and second steps are multiplied together to yield an estimate of the number of individuals with mental health insurance.

### *1. Proportion of Individuals With Health Insurance*

The CPS asks whether an individual had coverage at any time during the previous year, as well as what the source or sources of that coverage were. Respondents were allowed to list more than one category of coverage. For example, an individual may have been unemployed and covered by Medicaid during part of 1999 and then obtained employment that provided employer-sponsored health insurance for the remainder of the year. The survey does not record the specific period in the past year during which each source of insurance provided coverage.

An estimated 15 percent of individuals list more than one source of health insurance. The primary source of health insurance for these individuals was assigned according to the following hierarchy:

1. Medicare—The Federal health plan primarily serving individuals aged 65 years and older
2. Medicaid—The Federal-state health plan for low-income individuals
3. Federal Employee Health Benefits Plan (FEHBP)—The Federal health plan serving civilian Federal employees and their dependents
4. State employer-sponsored insurance—Health plans serving state employees and their dependents
5. Private employer-sponsored insurance—Health plans sponsored by private employers. These health plans do not include any government-sponsored employee health plans

6. TRICARE—The health plan for members of the armed forces and their dependents, sponsored by the U.S. Department of Defense
7. CHAMPVA—Health services provided to veterans and their dependents
8. Individually purchased—Health insurance purchased by individuals who are not required to become a member of a group plan
9. Indian Health System—Health services provided to Native Americans on tribal reservations
10. Uninsured—Individuals who have no health insurance

For example, an individual reporting TRICARE, as well as private employer-sponsored health insurance, would be assigned to private insurance because the latter is higher on the list.

The 1999 CPS did not separate individuals who were insured through the Medicaid program and SCHIP. Because the mental health benefits available to individuals enrolled in a separate SCHIP program (S-SCHIP) can be different from those available in the Medicaid program, it is useful to separate the two insurance sources. To do so, CMS administrative data on the number of individuals enrolled in state SCHIP programs (separated by M-SCHIP and S-SCHIP programs) were used. These numbers were then subtracted from the CPS estimate of the number of children receiving Medicaid to create mutually exclusive categories.<sup>16</sup>

## 2. Covered Lives With Mental Health Benefits

The next step is to estimate the percentage of those who have health insurance (covered

lives) with inpatient mental health benefits and those who have health insurance with outpatient mental health benefits. MEPS-IC data was the source used to derive these estimates for employer-sponsored health insurance. For public health insurance programs, the programs' published statements of services covered were used. The firm was the unit responding to the MEPS-IC survey. The number of covered lives was estimated by weighting each firm according to the number of lives covered by the firm.

MEPS-IC data were used to estimate the number of covered lives with inpatient mental health benefits in each cell of a two-by-five matrix, defined by whether the firm was self-insured or purchased health insurance, and according to five categories of firm size (1–9, 10–49, 50–499, 500–999, and 1,000 or more employees). MEPS-IC also was used to estimate the number of covered lives in each of these 10 cells. Table II.2 in Chapter II reports the ratio of covered lives with inpatient mental health insurance to total covered lives as the proportion with inpatient mental health insurance.

Using the CPS as the host database, figures from the MEPS-IC were adjusted for consistency with CPS estimates. Each cell in the MEPS-IC matrix of covered lives with inpatient mental health insurance was multiplied by a ratio adjustment factor. The numerator of the factor was the CPS estimate of the number of individuals with private employer-sponsored health insurance, and the denominator was the MEPS-IC estimate of covered lives. The denominator is the analogous MEPS-IC figure. The adjustment factor is computed separately for each firm size category (1–9, 10–49, 50–499, 500–999, and 1,000 or more) since firm size is recorded in both the CPS and MEPS-IC. Table II.2

<sup>16</sup>In 1999, only children were enrolled in SCHIP. Since that time some states have begun enrolling adults.

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reports the resulting estimates of the number of individuals with inpatient mental health insurance.

The procedure is repeated for outpatient mental health insurance.

### ***3. Population With Mental Health Benefits***

The number of individuals with mental health benefits was computed by multiplying the number of individuals with health insurance (Section 1 above) by the proportion of those with health insurance who have mental health benefits (Section 2 above). State-level information on the percentage of firms that cover mental health benefits as part of their benefit package is available for only 37 states as a consequence of sample size restrictions in the MEPS-IC. Therefore, state-level estimates of mental health insurance (see Table II.4) are presented only for these 37 states.

### ***4. Generosity of Mental Health Benefits***

In this study, four basic levels of generosity were established: mental health benefits at full parity (cost sharing, utilization limits, and dollar limits are the same as medical/surgical benefits); mental health benefits that meet the benchmark benefit of coverage (30 inpatient days, 20 outpatient visits, and prescription drug coverage); mental health benefits less than the benchmark; and health insurance that does not include mental health coverage.

The benchmark mental health benefit was established in consultation with an expert advisory panel to reflect current trends in the employer-sponsored health insurance market and is not intended to stand as a measure of adequacy. Data from the Mercer Worldwide Survey of Employer-Sponsored Health Insurance Plans indicated that 30 inpatient days and 20 outpatient visits was where the

biggest breaks occurred in utilization limits for plans with mental health insurance coverage (see Figures B.1 and B.2). Additionally, in 1999, FEHBP required all contracting health plans to cover a minimum 30 inpatient mental health days and 20 outpatient mental health visits.

Prescription drug coverage was included in the benchmark benefit package because such drugs are now considered a primary form of treatment for nearly all mental illnesses. In 1997, prescription drugs accounted for almost 13 percent of total mental health spending (Mark 2000). Prescription drug coverage also is considered “standard” in the employer-sponsored health insurance market (Kaiser Family Foundation et al., 2000).

The 1999 Mercer Worldwide survey of employer-sponsored health plans was the main source of information used to assess both the generosity of mental health coverage offered by employers and the limits placed on that coverage. A total of 2,737 randomly selected employers with at least 10 employees responded to the survey in 1999 (the sample was stratified across eight size categories).

Through the Substance Abuse and Mental Health Services Administration (SAMHSA), Mercer Worldwide provided estimates of the number of firms with mental health insurance coverage and no special utilization limits on benefits for mental health services. Mercer also provided estimates of the proportion of individuals whose mental health benefits were at least as generous as the benchmark level of mental health benefits. It was assumed that all firms with no special limits met the benchmark benefit.

We estimated the number of individuals who had mental health benefits at least as generous as the benchmark by multiplying the proportions provided by Mercer by the

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estimated number of individuals who had mental health insurance benefits from Section 3, above. Because the rates of outpatient mental health and inpatient mental health benefits were nearly identical, it was assumed that all individuals with inpatient mental health benefits also had outpatient mental health benefits.

It is important to note that the Mercer survey does not sample entities employing fewer than 10 people. Therefore, it was not possible to produce estimates for those with insurance provided through very small firms.

### 5. *Mental Health Parity*

Data from the National Conference of State Legislatures (2001) and the National Alliance for the Mentally Ill (2002) indicate that 24 states had full mental health parity laws, as of 2002. Yet, state parity laws provide for a number of exemptions. Under ERISA, states may not regulate self-insured employee benefit plans; thus, individuals covered by such plans are not subject to state parity laws. In addition, some state laws include an exemption for small employers.

To estimate the number of individuals who had employer-sponsored health insurance subject to state mental health parity laws required comparing estimates of the number of individuals who had health insurance through employer-sponsored self-insured plans with the number of individuals in plans who purchased insurance. These estimates were calculated from CPS and MEPS-IC data, as described in Section 2 above. Detailed state-by-state data tables on private employer-sponsored health insurance by firm size and

self-insured status are available from the authors at Mathematica Policy Research, Inc., upon request. Those in firms that self-insured or that had fewer than 50 employees in states whose parity law had a small-firm exemption, and retirees covered by employer-sponsored plans were subtracted from the population of individuals with employer-sponsored insurance.

Due to data limitations, the following adjustments were made:

- The MEPS-IC sample supports reliable figures for 37 states. Figures are not available for 13 states (Alaska, Arkansas, Delaware, Idaho, Nevada, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, West Virginia, and Wyoming) and the District of Columbia. For these states, we applied the national percentages of self-insured firms for firms with fewer than 50 employees and firms with 50 or more employees.
- Since the available data made it necessary to define small firms as those having 50 or fewer employees, the number of individuals covered by the parity laws in states whose small-firm exemption uses a firm size of fewer than 50 employees—Hawaii, Maine, and Virginia—is underestimated. Our estimates excluded all individuals in employer-sponsored plans that purchased insurance in firms that had fewer than 50 employees.
- The MEPS-IC and CPS data represent 1999. Our projections to 2002 are produced by applying 2002 state laws to population estimates for 1999.

Figure B.1. Maximum Number of Outpatient Visits Per Year for Firms With Limits on Mental Health Coverage

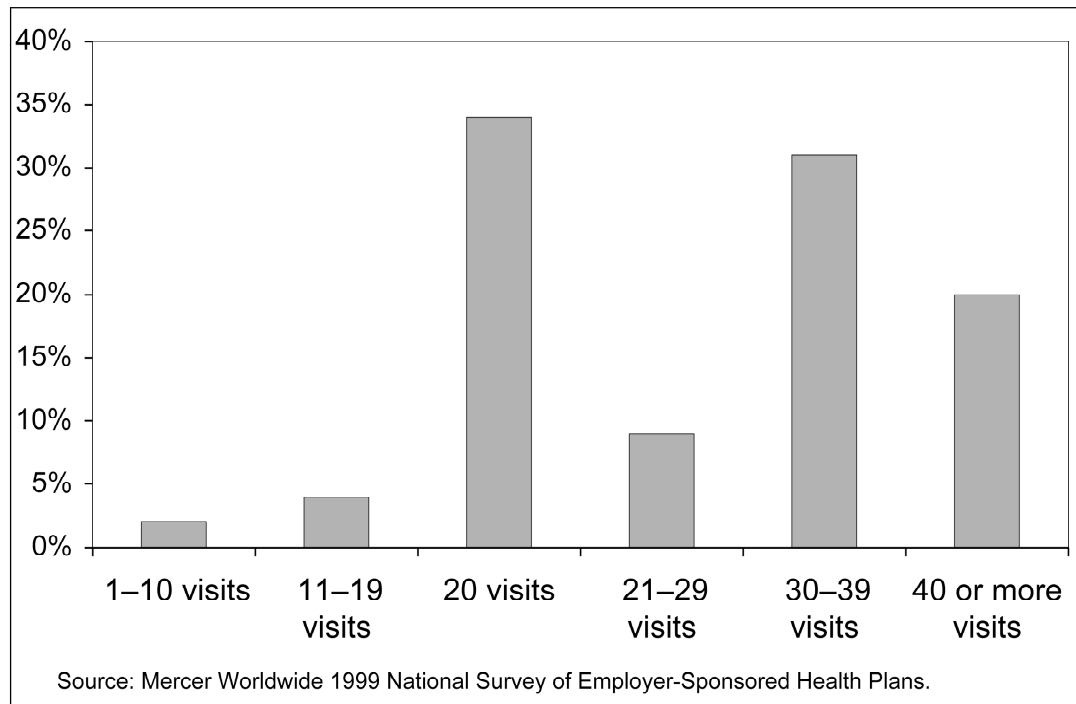
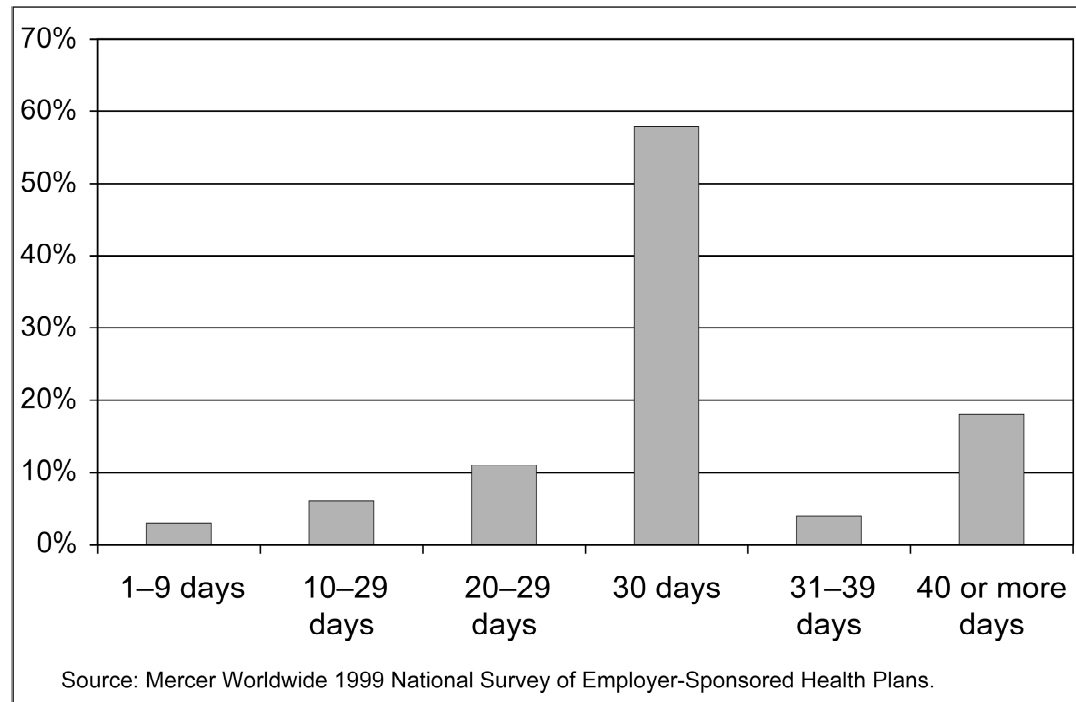


Figure B.2. Maximum Number of Inpatient Days Per Year for Firms With Limits on Mental Health Coverage





# IX. Appendix C: Expert Advisory Panel

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X.

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# Appendix D: Mental Health Benefits in Non- Medicaid S-SCHIP Plans, 2000

**Table D.1. Mental Health Benefits in Non-Medicaid S-SCHIP Plans, 2000**

| State                | Limits on Inpatient Mental Health Days                       | Limits on Outpatient Mental Health Visits   |
|----------------------|--|---|
| Alabama              | 30 days per year   | 20 visits per year  |
| Arizona              | 30 days per year   | 30 visits per year  |
| California           | 30 days per year   | 20 visits per year  |
| Colorado             | 45 days per year <sup>a</sup>                                | 20 visits per year  |
| Connecticut          | 60 days per year   | 30 visits per year  |
| Delaware             | 31 days per year wrap around <sup>b</sup>                    | 30 visits per year + 31 days per year wrap around <sup>b</sup>  |
| Florida              | 30 days per year   | 40 days per year  |
| Georgia              | 30 days per admission <sup>c</sup>                           | Visits to licensed applied psychologists limited to 24 hours per year, psychiatrists limited to 12 hours per year |
| Illinois             | No limits  | No limits   |
| Indiana              | No limits  | No limits   |
| Iowa                 | 30 or 60 days per year, depending on plan                    | 20 or 30 visits per year, depending on plan   |
| Kansas               | No limits  | No limits   |
| Kentucky             | No limits  | No limits   |
| Maine                | No limits  | 2 hours per week up to 30 weeks per year  |
| Massachusetts        | 60 days per year for non-managed care; none for managed care | No limits   |
| Michigan             | No limits  | No limits   |
| Mississippi          | No limits  | No limits   |
| Montana <sup>d</sup> | 21 days per year   | 20 visits per year  |
| Nevada               | No limits  | 24 visits per year  |

**Table D.1. Mental Health Benefits in Non-Medicaid S-SCHIP Plans, 2000 (Continued)**

|                |  |  |
|----------------|--|--|
| New Hampshire  | 15 days per year   | 20 visits per year   |
| New Jersey     | Two of New Jersey's three plans have no limits; the other is limited to 35 days per year | Two of New Jersey's three plans have no limits; the other is limited to 20 visits per year |
| New York       | 30 days per year   | 60 visits per year   |
| North Carolina | No limits  | 26 visits per year   |
| North Dakota   | 60 days per year   | No limits  |
| Oregon         | No limits  | No limits  |
| Pennsylvania   | 90 days per year   | 50 visits per year   |
| Texas          | No limits  | 30 visits per year   |
| Utah           | 30 days per year   | 30 visits per year   |
| Vermont        | No limits  | No limits  |
| Virginia       | No limits <sup>c</sup>   | 26 visits per year with possible extension of 26 sessions in first year                    |
| Washington     | No limits  | No limits  |
| West Virginia  | 30 days per year   | 26 visits per year   |
| Wyoming        | No limits  | No limits  |

Source: National Conference of State Legislatures, "Mental Health Benefits in Non-Medicaid SCHIP Plans, September 30, 2000."

<sup>a</sup> Inpatient days may be converted to outpatient visits at 2:1 rate.

<sup>b</sup> Delaware's Department of Children, Youth and Their Families provides an additional 31 days per year combined inpatient and outpatient of wraparound services once the SCHIP's managed care benefit package of 30 outpatient visits per year is exhausted.

<sup>c</sup> Limited to care in general acute care hospitals. Services administered in an IMD are not covered.

<sup>d</sup> Montana places no limits on benefits for children with severe emotional disturbances.





